

CERTIFICATE OF COVERAGE

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An Anthem Company

**Empire PPO
Alt PPO Plan**

Group Name: DEHIC
Dutchess Education Health Insurance Consortium
Group Number: 980925
Effective Date: July 1, 2018

SCHEDULE OF BENEFITS

Dependent Child(ren) age limit:	Coverage lasts until the end of the month in which the Child turns 26
Dependent Student Child(ren) age limit:	Coverage lasts until the end of the month in which the Child turns 26
Dependent Child(ren) coverage through Age 29:	Not applicable, see age limit listed above
Provider Network applicable to this Certificate	PPO Network
Benefit Period	Calendar Year

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Deductible • Individual • Family	None None	\$300 \$750	
Out-of-Pocket Limit • Individual • Family	\$5,080 \$12,700	\$1,050 \$2,000	

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 amount approved by another Host Plan, or the Participating Provider's charge, if less.
- The Allowed Amount for Non-Participating Providers will be determined as follows:
 - For Facilities, the Allowed Amount will be the average amounts paid by Us for comparable services to Our Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.
 - For all other Providers, the **Allowed Amount** is 90th percentile of the Fair Health rate.

See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.

OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Not Covered	See benefit for description
• Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Vasectomy	Use Cost-Sharing for appropriate service	30% Coinsurance after Deductible	See benefit for description
• Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible	See benefit for description

<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA. 	Covered in full	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> *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)	
EMERGENCY CARE	Participating Provider	Non-Participating Provider	Limits
	Member Responsibility for Cost-Sharing	Member Responsibility for Cost-Sharing	
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	Covered in full not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if Hospital admission	\$35 Copayment	\$35 Copayment not subject to Deductible	See benefit for description
Urgent Care Center	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description Out-of-network covered same as in-network for an Emergency Condition
PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider	Non-Participating Provider	Limits
	Member Responsibility for Cost-Sharing	Member Responsibility for Cost-Sharing	
Acupuncture	Covered in full	30% Coinsurance after Deductible	See benefit for description

<p>Advanced Imaging Services</p> <ul style="list-style-type: none"> Performed in an Office Setting Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Allergy Testing and Treatment Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office <p>Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>Covered in full</p>	<p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p>	<p>Covered in full</p>	<p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Autologous Blood Banking</p>	<p>Covered in full</p>	<p>30% Coinsurance after Deductible</p>	<p>See benefits for description</p>
<p>Cardiac Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>Included as part of Inpatient Hospital service Cost-Sharing</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>Included as part of Inpatient Hospital service Cost-Sharing</p>	<p>Unlimited visits per Benefit Period</p>

<p>Chemotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Chiropractic Services</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Clinical Trials</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Performed in a Freestanding Center Performed as Outpatient Hospital Services 	Covered in full	30% Coinsurance after Deductible	
Home Health Care	Covered in full	30% Coinsurance not subject to Deductible	Unlimited visits per Benefit Period
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
<p>Infusion Therapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	Covered in full	30% Coinsurance after Deductible	See benefit for description
	Covered in full	30% Coinsurance after Deductible	
	Covered in full	30% Coinsurance after Deductible	
	Covered in full	Not Covered	Home Infusion provided by Home Health Agency counts toward Home Health Care visit limits
Inpatient Medical Visits	Covered in full	30% Coinsurance after Deductible	See benefit for description
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> Medically Necessary Abortions Elective Abortions 	Covered in full	30% Coinsurance after Deductible	Unlimited
	See Surgical Services for Cost-Sharing	30% Coinsurance after Deductible	One (1) procedure per Benefit Period

<p>Laboratory Procedures</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care <ul style="list-style-type: none"> – Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA – Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center 	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>Included as part of Inpatient Hospital service Cost-Sharing</p>	<p>30% Coinsurance after Deductible</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>30% Coinsurance after Deductible (Birthing Center not Covered)</p>	<p>See benefit for description</p> <p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p>

<ul style="list-style-type: none"> Global fee for the Physician and Midwife Services for Delivery and for Postnatal Care 	Covered in full	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> Breastfeeding Support, Counseling and Supplies, Including Breast Pumps 	Covered in full	30% Coinsurance after Deductible	One (1) breast pump per pregnancy for the duration of breast feeding
Outpatient Hospital Surgery Facility Charge	Covered in full	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing	Covered in full	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in Outpatient Facilities 	Covered in full Covered in full Covered in full	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	Covered in full Covered in full Included as a part of inpatient Hospital services Cost-Sharing	30% Coinsurance after Deductible 30% Coinsurance after Deductible Included as a part of inpatient Hospital services Cost-Sharing	See benefit for description

<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Physical Therapy</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>	<p>Unlimited visits per Benefit Period</p>

<p>Occupational and Speech Therapies</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>	<p>30 combined visits per Benefit Period</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>Covered in full</p>	<p>Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when authorization is obtained</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants</p> <ul style="list-style-type: none"> Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Surgery Performed in a PCP Office Surgery Performed in a Specialist Office 	Covered in full	30% Coinsurance after Deductible	
Telemedicine Program	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description
Vision Therapy			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$15 Copayment	Not Covered	
	\$15 Copayment	Not Covered	
	\$15 Copayment	Not Covered	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	\$15 Copayment	Not Covered	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (Up to a 30-day supply) 	Covered in full	30% Coinsurance after Deductible	

<ul style="list-style-type: none"> • Diabetic Education <ul style="list-style-type: none"> – Performed in a PCP Office – Performed in a Specialist Office – Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	
Durable Medical Equipment and Braces	Covered in full	Not Covered	See benefit for description
Hospice Care			210 days per lifetime
<ul style="list-style-type: none"> • Inpatient • Outpatient 	<p>Covered in full</p> <p>Covered in full</p>	<p>Not Covered</p> <p>Not Covered</p>	5 visits for family bereavement counseling
Medical Supplies			See benefit for description
<ul style="list-style-type: none"> • Performed in an Office Setting or by a third-party supplier • Performed as Outpatient Hospital Services 	<p>Covered in full</p> <p>Covered in full</p>	<p>Covered same as in-network</p> <p>30% Coinsurance after Deductible</p>	
Orthotics	Covered in full	Not Covered	See benefit for description

Prosthetic Devices			Unlimited, See benefit for description
<ul style="list-style-type: none"> External Internal 	Covered in full	Not Covered	
	Covered in full	Not Covered	
INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	Covered in full	30% Coinsurance after Deductible	See benefit for description
Observation Stay	Covered in full	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	Covered in full	Not Covered	Unlimited days per Benefit Period
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Covered in full	30% Coinsurance after Deductible	Unlimited days per Benefit Period
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital)	Covered in full	30% Coinsurance after Deductible	See benefit for description

<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> Performed in a PCP or Specialist Office Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital)</p>	<p>Covered in full</p>	<p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> Performed in a PCP or Specialist Office Performed as Outpatient Hospital Services 	<p>\$15 Copayment</p> <p>Covered in full</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>Unlimited visits</p> <p>Up to 20 visits per Benefit Period may be used for family counseling</p>
<p>OTHER COVERED SERVICES</p>	<p>Participating Provider</p> <p>Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider</p> <p>Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Retail Health Clinic</p>	<p>\$15 Copayment</p>	<p>30% Coinsurance after Deductible</p>	<p>See benefit for description</p>

PREAUTHORIZATION SCHEDULE

Services Subject To Preauthorization. Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the following services:

Our Preauthorization is required before You receive certain Covered Services.

- All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns;
- Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification;
- Skilled Nursing Facility;
- Outpatient/Ambulatory Surgical Treatments (certain procedures);
- Chiropractic Care (after the 5th visit);
- Physical, Occupational, Vision and Speech Therapy;
- Diagnostics;
- Outpatient Treatments;
- Air Ambulance;
- High tech radiology services: MRI, MRA, PET, CAT, Nuclear Technology services;
- Durable Medical Equipment;
- Prosthetics and Orthotics;
- Assistive Communication Devices.

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

You or 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 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 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 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.

Failure to Seek Preauthorization or Provide Notification. If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay only 50% of the amount We would otherwise have paid for the care whichever is greater, up to \$5,000. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service. The penalty listed above will not apply to Medically Necessary inpatient Facility services from a BlueCard Provider.

**EMPIRE HEALTHCHOICE ASSURANCE, INC.
 PHARMACY RIDER SCHEDULE OF BENEFITS
 LARGE GROUPS**

**Dutchess Educational Health Insurance Consortium
 (DEHIC) ALT PPO Plan**

1. Annual Deductible Per Covered Person
 Per Calendar Year ♦ \$0

2. Pharmacy Copayments (Retail)

All drugs purchased through retail will be subject to one copayment for each supply of up to 30 days, as shown below.

<u>Category of Drug</u>	<u>Up to 30-day supply</u>
Generic	\$5
Brand (Multi-Source)	\$5, plus ancillary
Brand (Single-Source)	\$20

3. Pharmacy Copayments (Mail Order)

A supply of drugs for up to 90 days can be purchased through Empire’s mail order program, as shown below. You will be required to pay two copayments for each supply between 31 days and 90 days. You will be required to pay one copayment for each 30 day or less supply.

<u>Category of Drug</u>	<u>Up to 30-day supply</u>	<u>31 to 90-day supply</u>
Generic	\$5	\$10
Brand (Multi-Source)	\$5, plus ancillary charge	\$10, plus ancillary charge
Brand (Single-Source)	\$20	\$40



An **Anthem** Company

EMPIRE HEALTHCHOICE ASSURANCE, INC.

Rider for Prescription Drug Coverage

A. General. This rider amends the benefits of Your Certificate and provides Coverage for the following:

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

- 1. 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:

- 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.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription and 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 for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available.
- 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.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

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

2. **Refills.** We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after $\frac{3}{4}$ 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 Prescription Drug Schedule of Benefits section of this Certificate.

3. **Benefit and Payment Information.**

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

Prescription Drug Deductible. Except where stated otherwise, You must pay the amount in the Prescription Drug Schedule of Benefits section of this Certificate for Covered Prescription Drugs during each Benefit Period before We provide coverage.

Prescription Drug Out-of-Pocket Limit. When You have met Your Prescription Drug Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits for Prescription Drugs section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Prescription Drugs for the remainder of that Benefit Period. If You have other than individual coverage, the individual Prescription Drug Out-of-Pocket Limit applies to each person covered under this Certificate. Once a person within a family meets the individual Prescription Drug Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Prescription Drug Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Prescription Drug Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period.

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 have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug. 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 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.

- b. Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order or Designated Participating Pharmacy, You are responsible for paying the lower of:
- The applicable Cost-Sharing; or
 - The 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 the number on Your ID card or visit our website at www.empireblue.com to request approval.

- c. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.
- d. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

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

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

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

- Age-related macular edema;
- Eye conditions;
- Anemia, neutropenia, thrombocytopenia;
- Contraceptives;
- Cardiovascular;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis B, hepatitis C;
- Hereditary angioedema;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;

- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis);
- Transplant;
- RSV prevention.

- e. 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. If You are taking a Maintenance Medication, You may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then use the Mail Order Pharmacy or 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;
- Blood pressure;
- Contraceptives;
- Diabetes;
- High cholesterol.

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.empireblue.com or by calling the number on Your ID card. The Maintenance Drug list is updated periodically. Visit Our website at www.empireblue.com or call the number on Your ID card to find out if a particular Prescription Drug is on the maintenance list.

- f. Mail Order:** We will only Cover drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy. If you are taking a Maintenance Medication, you may get the first 30 day supply and up to one additional 30 day prescription refills of the Maintenance Medication at your local Retail Pharmacy. After that, you will have to fill your prescription through the mail order supplier or Designated Retail Pharmacy to get the In-Network level of benefits. If you do not use Our mail order supplier or Designated Retail Pharmacy, benefits will not be Covered.

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.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy, when that retail pharmacy has a participation agreement with Us in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

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

- g. Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six (6) times per calendar year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.empireblue.com or by calling the number on Your ID card.
- h. When a Brand-Name Drug Becomes Available as a Generic Drug:** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned.
- i. 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.empireblue.com or call number on Your ID card to find out more about this process.

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

- j. Supply Limits.** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

You may have an initial three-month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Pharmacy. For other contraceptive drugs and devices, for an initial three-month supply, You are responsible for up to three (3) Cost-Sharing amounts and You are responsible for up to nine (9) Cost-Sharing amounts for the remaining supply of a 12 month prescription. For subsequent 12 month dispensing of the same contraceptive drug or device, You are responsible for up to twelve (12) Cost-Sharing amounts.

Benefits will be provided for Prescription drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two (2) Cost-Sharing amounts for a 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 at www.empireblue.com or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Certificate.

- k. Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment.** If You have an Emergency Condition, You may immediately access, without Preauthorization, a five (5) day emergency supply of a Covered Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If You have a Copayment, it will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the emergency supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

In this paragraph, “Emergency Condition” means a substance use disorder condition that manifests itself by Acute symptoms of sufficient severity, including severe pain or the expectation of 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.

- l. 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 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.
- m. 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 injected anticancer medications Covered under the Outpatient and Professional Services section of this Certificate.
- n. 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 15-day supply (or appropriate amount of medication needed for an average infertility treatment cycle) of Your Prescription Order for certain drugs filled at a retail, mail order or Designated Pharmacy instead of the full Prescription Order. You initially pay a lesser Cost-Sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are Antivirals/Anti-infectives, Infertility, Iron Toxicity, Mental/Neurologic Disorders, Multiple Sclerosis, and Oncology. With the exception of Infertility drugs, this program applies for the first 60 days when You start a new Prescription Drug. For Infertility drugs, the program applies to Your infertility treatment cycle. 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.empireblue.com or by calling the number on Your ID card.

4. 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.

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

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.empireblue.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market 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.

- b. Step Therapy.** Step therapy is a process in which You may need to use one (1) type of Prescription Drug before We will Cover another as Medically Necessary. A “step therapy protocol” means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate.
- c. Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at www.empireblue.com or call the number on Your ID card.

5. Limitations/Terms of Coverage

- a.** We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
- b.** If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

- c.** Compounded Prescription Drugs will be Covered only when all of the ingredients are FDA approved, they require a prescription to be dispensed, the compound medication is not essentially the same as an FDA approved product from a drug manufacturer, and are obtained from a pharmacy that is approved for compounding. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. All compounded Prescription Drugs over \$150 require Preauthorization. Compound Prescription Drugs are on tier 3.
- d.** Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused 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.
- e.** Injectable drugs (other than self-administered injectable drugs) are not Covered under this section but are Covered under other sections of this Certificate. Your benefit for diabetic insulin, oral hypoglycemics, and diabetic Prescription Drugs, diabetic supplies, and equipment, will be provided under this section of the Certificate if the Cost-Sharing is more favorable to You under this section of the Certificate than the Additional Benefits, Equipment and Devices section of this Certificate.
- f.** 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.
- g.** We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over the counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF or as otherwise provided in this 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.
- h.** We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
- i.** 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.
- j.** 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.
- k.** A pharmacy need not dispense a Prescription Order that, in the pharmacist’s professional judgment, should not be filled.

6. General Conditions.

- a. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.
- b. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may 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.

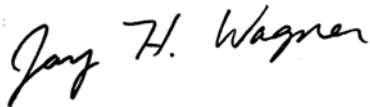
7. Definitions. Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

- a. **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.
- b. **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.
- c. **Designated Retail Pharmacy.** A Participating Retail Pharmacy that is contracted with Us or Our designee to dispense a 90 day supply of Maintenance Medication.
- d. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at www.empireblue.com or by calling the number on Your ID card.
- e. **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.

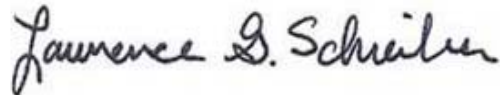
- f. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long term and which usually requires daily use of Prescription Drugs.
- g. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
- h. **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.

- i. **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.
- j. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, as contracted between Us and Our pharmacy benefit manager 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.
- k. **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.
- l. **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.
- 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.



Jay H. Wagner
Corporate Secretary



Lawrence G. Schreiber
President



An **Anthem** Company

EMPIRE HEALTHCHOICE ASSURANCE, INC.

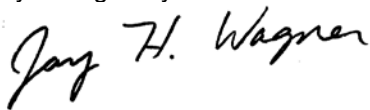
**RIDER TO PROVIDE COVERAGE FOR
ADVANCED REPRODUCTIVE TECHNOLOGIES (ART)**

This Rider amends your Empire HealthChoice Assurance, Inc. Contract or Certificate by adding this coverage to your Contract or Certificate.

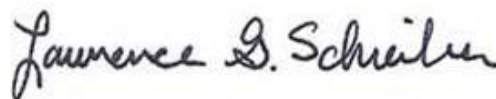
1. The following services are covered under the provisions of this Rider to Covered Persons who are infertile and who have failed to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. These services are available on an In-Network basis only from Participating Providers who are members of and contribute data to the Society of Assisted Reproductive Technologies. The services must be preauthorized by calling the Medical Management Program at least two weeks prior to the initiation of hormone treatment services. To receive benefits under this Rider services must be preauthorized. If You fail to obtain preauthorization, We will pay an amount of \$500 less than We would otherwise have paid for the services, or We will pay only 50% of the amount We would otherwise have paid for the services, whichever results in a greater benefit for You.
 - a. Three (3) Cycles of advanced reproductive technologies, including:
 - i. In Vitro Fertilization (IVF)
 - ii. Frozen Embryo Transfer (FET)
 - iii. Zygote Intrafallopian Transfer (ZIFT)
 - iv. Gamete Intrafallopian Transfer (GIFT)
 - v. Intracytoplasmic Sperm Injection (ICSI)
 - b. Medically necessary and appropriate diagnostic workup and radiology services.
 - c. Pathology and laboratory services, including:
 - i. Hormonal assays
 - ii. Swimup semen analysis, as appropriate
 - iii. Ultrasound exams
 - iv. Fertilization and embryo culture
 - v. Ova retrieval
 - vi. Embryo, gamete-zygote transfer
 - vii. Cryo preservation of blastocysts(s) and embryo(s) from covered IVF Cycles and oocytes as directed by Medical policy and up to the age of forty-five (45).
 - d. Medications necessary to the provisions above, including parenteral injection and oral ovulation induction drugs.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans

2. We will provide benefits for no more than three (3) Cycles of Assisted Reproductive Technologies per lifetime for members who are covered by this Certificate. A Cycle which is started, but is not completed is considered a cancelled Cycle. Cancelled Cycles will count towards the lifetime maximum as follows:
 - a. First covered Cycle – three (3) cancelled Cycles shall count as the first Cycle even if no transfer is performed.
 - b. Second covered Cycle – two (2) cancelled Cycles shall count as the second Cycle even if no transfer is performed.
 - c. Third covered Cycle – two (2) cancelled Cycles shall count as the third Cycle even if no transfer is performed.
 - A “Cycle” is defined as either:
 - i. all treatment that starts when preparatory medications used for ovarian stimulation with the intent of undergoing ART is administered for oocyte retrieval, IVF and fresh embryo transfer, or
 - ii. all treatment that may start with medications for endometrial preparation with the intent of undergoing ART for purposes of frozen embryo transfer.
 - A Cancelled Cycle is defined as one in which ovarian stimulation has been carried out with the intent of undergoing ART but which did not proceed to oocyte retrieval, or in the case of frozen embryo Cycles, to the transfer of embryos.
3. All frozen embryos stored after a completed Cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation Cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen Cycles) and elective single embryo transfer should be utilized when clinically appropriate.
4. The following services are not covered:
 - a. Related donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications).
 - b. Fallopian tube ligations and vasectomy reversals.
 - c. Surrogacy and any fees associated with it (maternity services are covered for Members acting as a surrogate mother).
 - d. Medical and surgical procedures that are experimental or investigational, unless such denial is overturned by an External Appeal Agent.
 - e. Services requested which are not medically appropriate
 - f. Services not specifically listed as covered in this Rider.
 - g. Services rendered by non-participating providers, unless authorized by the Medical Management Program.
5. Other Provisions. All of the terms, conditions and limitations of the Empire HealthChoice Assurance, Inc. Contract or Certificate to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Lawrence G. Schreiber
President



An Anthem Company

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO BENEFIT CONTRACT

GROUP NAME: DEHIC
GROUP NUMBER: 980925
EFFECTIVE DATE: July 1, 2017
PLAN NAME: PPO

The Contract, Certificate or Group Plan to which this Rider is attached is amended as follows:

Dependent Survivor Benefit Coverage

Notwithstanding any provision in the Termination section of this Contract, Certificate or Group Plan to the contrary, enrolled dependents of a Subscriber may be eligible to elect continued coverage under this Contract, Certificate or Group Plan in the event of a Subscriber's death. This continued coverage is in addition to, and not in lieu of, any other right to continue coverage under this Contract, Certificate or Group Plan. This Rider contains the requirements for such continued coverage.

Note: Survivors of COBRA enrollees are not eligible for dependent survivor coverage. A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue coverage under COBRA or state law.

Criteria for Dependent Survivor Coverage

The following criteria must be met for dependent survivors to continue coverage under the Contract, Certificate or Group Plan.

- The Subscriber must have been an employee or retiree of the group employer and covered under the Plan at the time of death; and
- An election to continue coverage must be made on behalf of the surviving dependents within 60 days of the date of the Subscriber's death; and,
- A copy of the Subscriber's death certificate must be provided to the Group Benefits Administrator.

Eligibility for Dependent Survivor Coverage

Eligible surviving dependents of a deceased Subscriber include:

- A spouse of the Subscriber who has not remarried; and,
- Dependent children or a proposed adoptive child of the surviving spouse and of the Subscriber who satisfy the eligibility requirements of this benefit plan. Only dependents of the Subscriber covered at the time of death or newborn children of the Subscriber born after the Subscriber's death are eligible for dependent survivor coverage.

Services provided by Empire HealthChoice Assurance Inc., a licensee of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans

Cost of Dependent Survivor Coverage

Dependent survivors may be required to pay the full premium. Any contribution to Premium is payable through the former employer. Check with the Group Benefits Administrator from the former employer for contribution rates. Coverage for dependent survivors will terminate after a failure to pay the required premium.

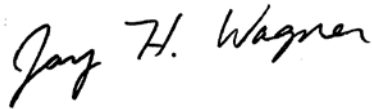
Termination of Dependent Survivor Coverage

Coverage of a dependent survivor terminates if:

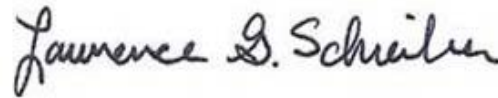
- Such survivor, who is the surviving spouse of the Subscriber, remarries; or
- Such survivor is a proposed adoptive child and the application for the adoption is withdrawn by the surviving spouse or is otherwise terminated; or
- Such survivor is a surviving dependent child of the Subscriber who no longer meets the eligibility requirements of the plan.

If coverage as a dependent survivor is terminated for any reason, eligibility ends and the dependent survivor may not reenroll in the Group Plan. However, a dependent who loses eligibility for dependent survivor coverage may be eligible to continue coverage under COBRA or state law, as applicable, or to convert to a direct pay contract. Refer to the Continuation of Coverage and Conversion sections of this Contract, Certificate or Group Plan for information on coverage options.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.



Jay H. Wagner
Corporate Secretary



Lawrence G. Schreiber
President



An Anthem Company

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO BENEFIT CONTRACT

GROUP NAME: DEHIC
GROUP NUMBER: 980925
EFFECTIVE DATE: August 1, 2018
PLAN NAME: PPO

The Contract, Certificate or Group Plan to which this Rider is attached is amended as follows:

Dependent Survivor Benefit Coverage

Notwithstanding any provision in the Termination section of this Contract, Certificate or Group Plan to the contrary, enrolled dependents of a Subscriber may be eligible to elect continued coverage under this Contract, Certificate or Group Plan in the event of a Subscriber's death. This continued coverage is in addition to, and not in lieu of, any other right to continue coverage under this Contract, Certificate or Group Plan. This Rider contains the requirements for such continued coverage.

Note: Survivors of COBRA enrollees are not eligible for dependent survivor coverage. A covered dependent who is not eligible for dependent survivor coverage may be eligible to continue coverage under COBRA or state law.

Criteria for Dependent Survivor Coverage

The following criteria must be met for dependent survivors to continue coverage under the Contract, Certificate or Group Plan.

- The Subscriber must have been an employee or retiree of the group employer and covered under the Plan at the time of death; and
- An election to continue coverage must be made on behalf of the surviving dependents within 60 days of the date of the Subscriber's death; and,
- A copy of the Subscriber's death certificate must be provided to the Group Benefits Administrator.

Eligibility for Dependent Survivor Coverage

Eligible surviving dependents of a deceased Subscriber include:

- A spouse of the Subscriber and,
- Dependent children, stepchildren or a proposed adoptive child of the surviving spouse and of the Subscriber who satisfy the eligibility requirements of this benefit plan. Only dependents of the Subscriber covered at the time of death or newborn children of the Subscriber born after the Subscriber's death are eligible for dependent survivor coverage.

Services provided by Empire HealthChoice Assurance Inc., a licensee of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans

Cost of Dependent Survivor Coverage

Dependent survivors may be required to pay the full premium. Any contribution to Premium is payable through the former employer. Check with the Group Benefits Administrator from the former employer for contribution rates. Coverage for dependent survivors will terminate after a failure to pay the required premium.

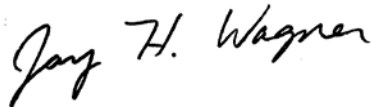
Termination of Dependent Survivor Coverage

Coverage of a dependent survivor terminates if:

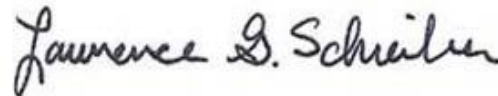
- Such survivor is a proposed adoptive child and the application for the adoption is withdrawn by the surviving spouse or is otherwise terminated; or
- Such survivor is a surviving dependent child of the Subscriber who no longer meets the eligibility requirements of the plan.

If coverage as a dependent survivor is terminated for any reason, eligibility ends and the dependent survivor may not reenroll in the Group Plan. However, a dependent who loses eligibility for dependent survivor coverage may be eligible to continue coverage under COBRA or state law, as applicable, or to convert to a direct pay contract. Refer to the Continuation of Coverage and Conversion sections of this Contract, Certificate or Group Plan for information on coverage options.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.



Jay H. Wagner
Corporate Secretary



Lawrence G. Schreiber
President



An Anthem Company

This is Your

CERTIFICATE OF COVERAGE

Issued by: Empire HealthChoice Assurance, Inc.

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

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

- 1. In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in the network applicable to Your plan as indicated in the Schedule of Benefits section of this Certificate. You should always consider receiving health care services first through the in-network benefits portion of this Certificate.
- 2. Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

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.

Handwritten signature of Jay H. Wagner in black ink.

Jay H. Wagner
Corporate Secretary

Handwritten signature of Lawrence G. Schreiber in black ink.

Lawrence G. Schreiber
President

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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RIDERS.....	END OF CERTIFICATE

SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout this Certificate.

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

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

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

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

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

Benefit Period: The length of time We will cover benefits for Covered Services. The Schedule of Benefits section of this Certificate shows if Your Plan's Benefit Period is a Calendar Year or a Plan Year. If Your coverage ends before the end of the year, then Your Benefit Period also ends.

Blue Distinction Center (BDC) Facility: Blue Distinction Centers have met or exceeded national quality standards for care delivery.

Calendar Year: A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

Certificate: This Certificate issued by Empire HealthChoice Assurance, Inc, including the Schedule of Benefits and any attached riders.

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

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

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

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

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

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered

Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a 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 Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (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.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist;

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

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

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to 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 rehabilitative 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.

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

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

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

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover.

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

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

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

Non-Participating Provider: A Provider who doesn't have a contract with Us or another Blue Cross and/or Blue Shield plan to provide services to You. You will pay more to see a Non-Participating Provider.

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

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

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

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Participating Provider: A Provider who has a contract with Us or another Blue Cross and/or Blue Shield plan to provide services to You. A list of Participating Providers and their locations is available on Our website at www.empireblue.com or upon Your request to Us. The list will be revised from time to time by Us.

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 12-month period beginning on the effective date of the Certificate 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, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

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. Except where stated otherwise, Coverage of Prescription Drugs is subject to the "Prescription Drug Coverage" section of the Certificate.

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 and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following 28 counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, 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.

Subscriber: The person to whom this Certificate is issued.

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

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

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

Us, We, Our: Empire HealthChoice Assurance, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

SECTION II: HOW YOUR COVERAGE WORKS

- A. Your Coverage Under this Certificate.** Your employer (referred to as the “Group”) has purchased a Group health insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.
- B. Covered Services.** You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:
- Medically Necessary;
 - Listed as a Covered Service;
 - Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
 - Received while Your Certificate is in force.
- C. Participating Providers.** To find out if a Provider is a Participating Provider, and for details about licensure and training:
- Check Your Provider directory, available at Your request,
 - Call the number on Your ID card; or,
 - Visit Our website at www.empireblue.com.
- D. The Role of Primary Care Physicians.** This Certificate does not have a gatekeeper, usually known as a Primary Care Physician (“PCP”). You do not need a Referral from a PCP before receiving Specialist care.

You may need to request Preauthorization before You receive certain services. See the Preauthorization Schedule section of this Certificate for the services that require Preauthorization.

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

To see a Provider, call his or her office and tell the Provider that You are an Empire Member in the network applicable to Your plan as indicated in the Schedule of Benefits of this Certificate 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.

- E. Out-of-Network Services.** We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.
- F. Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed in the Preauthorization Schedule section of this Certificate.
- G. Preauthorization/Notification Procedure.** If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number on Your ID card.

You or 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 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 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 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. Failure to Seek Preauthorization or Provide Notification. If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay only 50% of the amount We would otherwise have paid for the care, up to the maximum penalty amount indicated on the Preauthorization Schedule section of this Certificate. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service. The penalty listed above will not apply to Medically Necessary inpatient Facility services from a BlueCard Provider.

I. 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.

J. 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; and
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

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 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.

K. Protection from Surprise Bills.

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

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
 - A participating Physician is unavailable at the time the health care services are performed;
 - A non-participating Physician 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 Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the Referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
 - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
 - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
 - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your In-Network Copayment, Deductible or Coinsurance.

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

- **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. Disputes are submitted by completing the IDRE application form, which can be found

at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

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

M. 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 team work 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.

N. Important Telephone Numbers and Addresses.

- **CLAIMS**

Refer to the address on Your ID card
(Submit paper claim forms to this address)

www.empireblue.com

(Submit electronic claim forms through Our website)

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**

Call the number on Your ID card

- **ASSIGNMENT OF BENEFITS FORM**

Refer to the address on Your ID card
(Submit assignment of benefits form for surprise bills to this address.)

- **MEDICAL EMERGENCIES AND URGENT CARE**

Call the number on Your ID card
Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:00 p.m.

- **MEMBER SERVICES**
Call the number on Your ID card
Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:00 p.m.
E.S.T.
- **PREAUTHORIZATION**
Call the number on Your ID card
- **OUR WEBSITE**
www.empireblue.com

SECTION III: ACCESS TO CARE AND TRANSITIONAL CARE

A. Authorization to a Non-Participating Provider. If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be 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 an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

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

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

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

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, 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.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Benefit Period before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Benefit Period. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Benefit Period, no further Deductible will be required for any person covered under this Certificate for that Benefit Period.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

- 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 Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.
- C. Coinsurance.** Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**
- D. In-Network Out-of-Pocket Limit.** When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for the remainder of that Benefit Period. If You have other than individual coverage, once a person within a family meets the individual In-Network 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 Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, does not apply toward Your In-Network Out-of-Pocket Limit; and Cost-Sharing for in-network services does not apply towards Your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Certificate does not apply toward Your In-Network Out-of-Pocket Limit.

- E. Out-of-Network Out-of-Pocket Limit.** This Certificate has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Benefit Period. If You have other than individual coverage, once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for

100% of the Allowed Amount for Covered out-of-network Services for the rest of that Benefit Period 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-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the Covered out-of-network Services for the rest of that Benefit Period for the entire family. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the Preauthorization Schedule section of this Certificate does not apply toward Your Out-of-Network Out-of-Pocket Limit.

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

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

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

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider's charge, if less.

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

- For Facilities, the Allowed Amount will be the average amounts paid by Us for comparable services to Our Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.
- For all other Providers, the Allowed Amount applicable to Your Certificate is listed on the Schedule of Benefits.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website at www.empireblue.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

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 the Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

H. Inter-Plan Programs

1. Out-of-Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside of the geographic area We serve (the "Empire Service Area"), the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. BlueCard® Program. Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing

arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. Special Cases: Value-Based Programs.

BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments.

4. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees. Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

5. Non-Participating Providers Outside Our Service Area.

a. Allowed Amounts and Member Liability Calculation. When Covered Services are provided outside of Empire's Service Area by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

b. Exceptions. In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. Blue Cross Blue Shield Global Core® Program. If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United State may be different from services received in the United States. The plan only covers Emergency, including ambulance and Urgent Care outside of the United States. Remember to take an up to date health ID card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

How claims are paid with Blue Cross Blue Shield Global Core. In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core;
and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need Blue Cross Blue Shield Global Core claim forms, You can get international claim forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

SECTION V: WHO IS COVERED

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

B. Types of Coverage. We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **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 age set forth in the Schedule of Benefits section of this Certificate. 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, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

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

1. If You, the Subscriber elect coverage before becoming eligible, or within 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 90 days.
2. If You, the Subscriber do not elect coverage upon becoming eligible or within 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 30 days thereafter, coverage for Your Spouse and Child starts on the date of such marriage. If We do not receive notice within 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 60 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 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, 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 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice and provided that You pay any additional Premium when due.

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

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 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 30 days of the loss of coverage. The effective date of Your coverage will be the date indicated on the application along with the Premium payment.

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

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

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will be the date indicated on the application along with the Premium payment.

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 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 the number on Your ID card or visit Our website at www.empireblue.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 Benefit Period, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.
- 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.empireblue.com, or will be mailed to You upon request.

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

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

- C. Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.
- D. Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is

available on Our website at www.empireblue.com, or will be mailed to You upon request.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We

Cover mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

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

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

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

F. Family Planning and Reproductive Health Services. We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Rider for Prescription Drug Coverage section of this Certificate, counseling on use of contraceptives, and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

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

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Rider for Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- 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 bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

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

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

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

SECTION VII: AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

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

A. Emergency Ambulance Transportation. We Cover Pre-Hospital Emergency Medical Services 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 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.

We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

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

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

C. 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 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
- 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. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department.**

We do not Cover follow-up care or routine care provided in a Hospital emergency department.

- 2. Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital. Any inpatient Hospital services received from a non-participating Hospital after Your medical

condition no longer prevents Your transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and arranged for a transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing.

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

If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician services.

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

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

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.
2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center or Physician outside 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 requirements that apply to these benefits.

- A. Acupuncture.** We Cover acupuncture services rendered by a Health Care Professional licensed to provide such services.
- B. Advanced Imaging Services.** We Cover PET scans, MRI, nuclear medicine, and CAT scans.
- C. 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.
- D. 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.
- E. Chemotherapy.** We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Rider for Prescription Drug Coverage section of this Certificate.
- F. 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.
- G. 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 Appeal sections of this Certificate.

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

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

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

- H. Dialysis.** We Cover dialysis treatments of an Acute or chronic kidney ailment.
- I. Home Health Care.** We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational, or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to the number of visits on the Schedule of Benefits section of this Certificate. 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 Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services benefits.

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

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. Exclusions and Limitations. We do not Cover:

- a. In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- b. Costs for an ovum donor or donor sperm;

- c. Sperm storage costs;
- d. Cryopreservation and storage of embryos;
- e. Ovulation predictor kits;
- f. Reversal of tubal ligations. Reversal of vasectomies;
- g. Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- h. Cloning; or
- i. 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.

- K. Infusion Therapy.** We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.
- L. Interruption of Pregnancy.** We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per Benefit Period.
- M. 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.
- N. 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 or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding.
- O. Office Visits.** We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.
- P. 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.

- Q. 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.
- R. Prescription Drugs for Use in the Office and Outpatient Facilities.** We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Rider for Prescription Drug Coverage section of this Certificate.
- S. Rehabilitation Services.** We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to the number of visits listed on the Schedule of Benefits section of this Certificate.
- T. 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 authorization 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.
 - a. The second opinion must be given by a board certified Specialist who personally examines You.
 - b. If the first and second opinions do not agree You may obtain a third opinion.
 - c. The second and third surgical opinion consultants may not perform the surgery on You.
 - 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.
- U. Surgical Services.** We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

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

V. Oral Surgery. We Cover the following limited dental and oral surgical procedures:

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

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

X. 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.

Y. 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.

- **Online visits.** Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Member Access. To begin the online visit, log on to www.livehealthonline.com and establish an online account by providing some basic information about You and Your insurance plan. Before You connect to a Doctor, You will be asked to identify: the

kind of condition You want to discuss with the Doctor, list Your local pharmacy, provide information for the credit card You want Your cost share for the visit to be billed to, agree to the terms of use, and select an available Physician. If You are not in New York State when You seek an online visit, You will need to check to be sure an online Doctor is available in the state You are in because online Doctors are not available in every state.

The visit with the Physician will not start until You provide the above information and click "connect." The visit will be documented in an electronic health record. You may access Your records and print them, and may email or fax them to Your Primary Care Physician.

Note about Covered Services. Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor;
- To request precertification for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

Z. 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).

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.

To maximize Your benefits, You should call Our Transplant Department to as soon as You think You may need a transplant to talk about Your benefit options. You must do this before You have an evaluation and/or work-up for a transplant. We will help You maximize Your benefits by giving You coverage information, including details on what is Covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Services number on the back of Your ID card and ask for the transplant coordinator. Even if We give a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before We will Cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to Us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where Your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be Covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

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

AA.Vision Therapy. We Cover vision therapy to improve vision skills, such as eye movement control and eye coordination.

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. Autism Spectrum Disorder. We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

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

We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

- 3. 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. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.
- 4. 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.
- 5. Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are

otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

6. **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 Rider for Prescription Drug Coverage under this Certificate.
7. **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 Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; 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 Certificate for the Cost Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. 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
 - Blood glucose kit
 - Blood glucose strips (test or reagent)
 - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
 - Cartridges for the visually impaired
 - Diabetes data management systems
 - Disposable insulin and pen cartridges
 - Drawing-up devices for the visually impaired

- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- 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.

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 blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

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

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

For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Certificate.

C. 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 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.

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 limited to the number of days indicated on the Schedule of Benefits section of this Certificate. 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; homemaker, or caretaker.

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. Orthotics. We Cover orthotics (e.g., 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.

G. 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 do not Cover eyeglasses or contact lenses.

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 prosthetic devices. We also Cover the cost of repair and 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.

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 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 occur within a period of not more than 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 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or 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.

- 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 of 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. Rehabilitation Services.** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Certificate.
- H. 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. Coverage for non-custodial care is limited to the number of days indicated on the Schedule of Benefits section of this Certificate.
- I. End of Life Care.** If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited 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 rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

- J. Centers of Excellence.** Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover the following Services when performed at Centers of Excellence:
- Transplants.

K. 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 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.

- 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.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders 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(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

- 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, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health 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 mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist; or a professional corporation or a university faculty practice corporation thereof.
- 3. Limitations/Terms of Coverage.** We do not Cover:
 - Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
 - Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
 - Services solely because they are ordered by a court.

B. Substance Use Services.

- 1. Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and

treatment of substance use disorder. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission 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 disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission 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 disorder, including but not limited to partial hospitalization program services, intensive outpatient program service, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission 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.

We also Cover up to 20 outpatient visits per Benefit Period for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII. WELLNESS BENEFITS

A. Voluntary Clinical Quality Programs.

The purpose of these voluntary clinical quality programs is to promote good health and early detection of disease. They are designed to encourage eligible Members to obtain certain covered Preventive Care or other recommended care covered under this Certificate that was not received within the recommended timeframe. For instance, a program may be designed to encourage You to bring Your child to his or her PCP for a well-child or well-baby care visit if You missed a recommended check-up, or may encourage You to get certain screening tests such as a mammogram if You have not been tested within the recommended age range. Or, a program may encourage You to have a medical visit within a specific time period such as a postpartum checkup within a set number of days after delivery of a newborn, or a home visit so You can provide a blood sample for a recommended laboratory test.

1. **Description.** These voluntary clinical quality programs are designed to encourage You to get certain preventive, wellness, or other recommended care when You need it based on recommended clinical guidelines. These programs are not guaranteed and Your participation is optional. We will give You the choice, and if You choose to participate in any program for which You qualify, and obtain the recommended care within the program's timeframe, You will receive an incentive. The incentive will take the form of:
 - a. a gift card in the amount of \$50 or retailer coupons, such as for discounts on eye glasses; or
 - b. a home test kit at no cost to allow You to conveniently collect a specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. In this case, You may need to pay any cost shares that normally apply to covered laboratory tests under Your benefit plan, but the home test kit will be free to You.
 - c. a home visit to allow You to provide a specimen for certain covered laboratory tests, or for certain biometric screenings. In this case, You may need to pay any cost shares that normally apply to covered laboratory tests, but the home visit will be free to You.

If You have any questions about whether receipt of a gift card or retail coupon results in taxable income to You, We recommend that you consult Your tax advisor.

2. **Eligibility.** You, the Subscriber, and the Subscriber's covered Spouse, and each covered Dependent can participate in the Voluntary Clinical Quality Program(s) if the targeted service applies, based on the recommended clinical guidelines the program promotes. These programs will be offered to Members who have certain conditions, who fall within certain age ranges, or who are due to receive certain recommended preventive or other care based on a recommended timeframe. For example:
 - a. Members age 50-75 years who have not undergone colorectal cancer screening as recommended by the American Cancer Society may be eligible to participate in a program designed to encourage these members to obtain a recommended preventive colorectal cancer screening, such as a fecal occult blood screening test.
 - b. Members age 50-74 years who have not had a mammography screening as recommended by the United States Preventive Services Task Force may be eligible to participate in a program designed to encourage these members to obtain the screening through the offer of a gift card awarded upon receipt of documentation that the screening was completed.
3. **Participation.** If You are eligible for a clinical quality program We offer, We will contact You by phone or mail to offer You the chance to participate. You may also call Us at the phone number on Your ID card if You have any questions regarding program participation. We will explain to You the care You are recommended to receive and the timeframe within which You need to receive it to be eligible for the reward if applicable.
4. **Rewards.** Rewards for participation in a clinical quality program and completion of the identified services within the specified timeframe include monetary rewards in the form of a gift card or

retailer coupon such as for discounts on eyeglasses, so long as the recipient is encouraged to use the reward for a product or service that promotes good health. In other cases, You will receive a home test kit at no cost to make it more convenient for You to receive the recommended care.

SECTION XIV: 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 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.
- D. Cosmetic Services.** We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.
- E. Coverage Outside of the United States, Canada or Mexico.** We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services 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 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.
- G. Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

- H. Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).
- I. Foot Care.** We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.
- J. Government Facility.** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law 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.
- K. Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.
- L. Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.
- M. Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
- N. No-Fault Automobile Insurance.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.
- O. Services Not Listed.** We do not Cover services that are not listed in this Certificate as being Covered.
- P. Services Provided by a Family Member.** We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.
- Q. Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
- R. Services with No Charge.** We do not Cover services for which no charge is normally made.
- S. Vision Services.** We do not Cover the examination or fitting of eyeglasses or contact lenses.
- T. War.** We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.
- U. Workers' Compensation.** We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XV: 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.empireblue.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate; on Your ID card or visiting Our website at www.empireblue.com.
- C. Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 18 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 18 month 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. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

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

F. Pre-Service Claim Determinations.

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

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

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 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour 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 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

H. Payment of Claims. Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 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 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XVI: GRIEVANCE PROCEDURES

- A. Grievances.** Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.
- B. Filing a Grievance.** You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

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

We keep all requests and discussions confidential and We 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.

- 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 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

- D. Grievance Appeals.** If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 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 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 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

E. Assistance. If You remain dissatisfied with Our Appeal determination or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

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

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY. 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XVII: UTILIZATION REVIEW

- A. Utilization Review.** We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All 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) with respect to 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 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. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. 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.empireblue.com.

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 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

- 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 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 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 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 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.

C. Concurrent Reviews

1. Non-Urgent Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 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 15 calendar days of the end of the 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 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 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 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 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. 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.

4. Inpatient Substance Use Disorder Treatment at Participating OASAS Certified Facilities. Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 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.

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

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

E. 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 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 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 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 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 72 hours of Our receipt of the information or 15 calendar days of the end of the 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 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 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 72 hours of Our receipt of the information or 15 calendar days of the end of the 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 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

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

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

- F. 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.
- 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 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

- 1. Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
 - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.
- 2. Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your

condition:

- That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

- 1. Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 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 30 calendar days after receipt of the Appeal request.
- 2. Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.
- 3. Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 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 24 hours after the determination is made, but no later than 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 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

- 4. Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 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 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 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. 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 XVIII: 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, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

- B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.** If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

- C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:
1. Standard health services are ineffective or medically inappropriate; **or**
 2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
 3. There exists a clinical trial or rare disease treatment (as defined by law).

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

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

- D. Your Right to Appeal a Determination that a Service is Out-of-Network.** If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

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

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

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

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

- F. The External Appeal Process.** You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

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

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

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

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

- G. 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 XIX: COORDINATION OF BENEFITS

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

A. Definitions.

1. "Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. "Plan" is other group health coverage with which We will coordinate benefits. The term "plan" includes:
 - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
 - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
 - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.
3. "Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. "Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

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

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

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - The plan of the parent who has custody will be primary;
 - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
 - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

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

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

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

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

1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 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 XX: 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 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the Child turns the maximum age indicated on the Schedule of Benefits section of this Certificate.
6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application we will rescind coverage 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. 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. The date that the Group Contract is terminated. If We terminate and/or 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 90 days' prior written notice.
10. If We elect to terminate or cease 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 180 days prior to when the coverage will cease.
11. 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.
12. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
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 30 days prior to when the coverage will cease.

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

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

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

SECTION XXI: 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 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 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;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 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 XXII: 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 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 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 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 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 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 29 if he or she:

1. Is under the age of 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 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 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 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 XXIII: CONVERSION RIGHT TO A NEW CONTRACT AFTER TERMINATION

- A. Circumstances Giving Rise to Right to Conversion.** You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.
- 1. Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.
 - 2. If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.
 - 3. On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.
 - 4. Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
 - 5. Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
 - 6. Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.
 - 7. Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.
- B. When to Apply for the New Contract.** If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 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 XXIV: 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. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. 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 30 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 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Contract with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

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

10. Fraud and Abusive Billing. We have processes to review claims before and after payment to detect fraud and abusive billing.

Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit. The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

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

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

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

15. Input in Developing Our Policies. Subscribers may participate in the development of Our policies by calling or writing to Member Services. We encourage You to send suggestions about how We may improve Our products or Our policies and procedures. Also, We regularly conduct customer satisfaction surveys that permit You to share Your suggestions and opinions with Us.

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

17. More Information about Your Health Plan. You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines including clinical review criteria relating to a step therapy protocol override determination.

- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

18. Notice. Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or to the address of the Group. 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: Empire Member Services, P.O. Box 1407, Church Street Station, New York, NY 10008.

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

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

21. Renewal Date. The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by this Certificate, or by the Group upon 30 days' prior written notice to Us.

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

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

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

24. Service Marks. Empire HealthChoice Assurance, Inc. ("Empire") is an independent corporation organized under the New York Insurance Law. Empire also operates under licenses with the Blue Cross and Blue Shield Association, which licenses Empire to use the Blue Cross and/or Blue Shield service marks in a portion of New York State. Empire does not act as an agent of the Blue Cross and Blue Shield Association. Empire is solely responsible for the obligations created under this agreement.

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

26. 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.

27. 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 is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

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

28. 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.

29. Time to Sue. No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this 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.

30. 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. TTY/TDD services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

31. 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.

- 32. 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.
- 33. Who May Change This Certificate.** This Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. 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 President or person designated by the President.
- 34. Who Receives Payment Under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.
- 35. 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.
- 36. 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.

- 37. Your Rights.**
- 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.

SECTION XXV: OTHER COVERED SERVICES

- A. Retail Health Clinic Care:** Basic health care services provided to Members on a “walk-in” basis. Retail Health Clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.
- B. Your Rights and Responsibilities.** As a Member, You have certain 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. That means giving You access to Our Participating Providers and the information You need to make the best decisions for Your health and welfare. 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 health care Providers to make a treatment plan that You all agree on.
- Follow the health care plan that You have agreed on with Your doctors or health care Providers.
- Give Us, Your doctors and other health care Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your health plan. This may include information about other health and insurance benefits You have along with Your coverage with Us.
- Inform Member Service if You have any changes to Your name, address or family members covered under Your plan.

If You need more information or would like to contact Us, please go to www.empireblue.com and select Customer Support > Contact Us. Or call the number on Your ID card.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for our health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber or your plan for payment purposes.
- We may share PHI with your health care providers so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with care management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may use your publicly and/or commercially available data about you to provide you with information about available health plan benefits and services.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit empireblue.com/health-insurance/about-us/privacy for more information.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

You may have an opportunity to receive email communications involving limited PHI such as welcome materials. We will obtain your consent before initiating these email communications.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice also require your written OK. You always have the right to revoke any written OK you provide,

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities.
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents).
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety.
- Special government functions, for Worker's Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity and Language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information in various health care operations, which include identifying health care disparities, developing care management programs and educational materials and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through email. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent to use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Empire BlueCross BlueShield (Empire), Empire does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Empire does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not pre-empt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be contacted by phone, just let the caller know, and we won't reach out this way anymore or call 1-844-203-3796 to add your phone number to our Do Not Call list.

Complaints

If you think we have not protected your privacy, you can file a complaint with us at the Customer Service phone number printed on your ID card. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services, Office for Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint, or talk with you about privacy issues.

COPIES AND CHANGES

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

STATE NOTICE OF PRIVACY PRACTICES

As mention in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company - without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Bengali

আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu

یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنے کے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہو سکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish

דעם מעלדונג האט וויכטיגע אינפארמאציע וועגן אייער אפלקאציע אדער קאווערידזש. קוקט פאר נויטיגע דאטעס אין דעם מעלדונג. איר וועט מעגליך דארפן נעמען אקציע קודם געוויסע דעדליינד צו האלטן אייערע געזונט קאווערידזש אדער העלפן מיט קאסט. איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. רופט די מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711).

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

CERTIFICATE OF COVERAGE

empireblue.com

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.



An Anthem Company

CERTIFICATE OF COVERAGE

empireblue.com

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.



An Anthem Company



An Anthem Company

Empire Blue Cross and Blue Shield Blue View Vision Member Certificate

Empire Blue View Vision

Group Name:	DEHIC
Group Number:	980925
Effective Date:	July 1, 2018

**Blue View Vision
PO Box 8504
Mason, OH 45040-7111
(866) 723-0515**

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Welcome!

Thank you for choosing Empire Blue Cross and Blue Shield (Empire) for your vision care coverage.

The following materials make up your certificate:

- this booklet
- your application
- any amendments

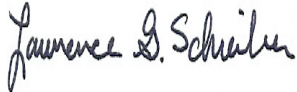
Your employer also has the following documents which are part of the terms of your plan:

- the group contract
- the group master application

This booklet contains important information such as what vision care services are covered and how they will be covered. It replaces any older booklets issued to you for your vision plan.

Within the booklet the insured person is referred to as “you” or “your”. Empire is referred to as “we,” “us” or “our.” All italicized words are defined in the “Definitions” section of this booklet.

Please review this booklet so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage.



Lawrence Schreiber
President and GM, Empire Blue Cross Blue Shield

How to Contact us

For Customer Service

Empire Blue Cross and Blue Shield
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line

www.empireblue.com

Hours of operation

Monday – Saturday:

7:30 a.m. to 11:00 p.m. EST

Sunday:

11:00 a.m. to 8:00 p.m. EST

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Schedule of Benefits

This schedule is an outline of your benefits. You need to refer to the entire booklet for complete information about the benefits, conditions, limitations and exclusions of your plan.

Coverage Year	Calendar Year
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Vision Care Services	Benefit Frequency	In-Network	Out-of-Network
Eye Exam (with dilation as necessary)	Limited to one exam per member every 24 months*	\$5 copayment	reimbursed up to \$30
Standard Plastic Lenses	Limited to one set of lenses per 24 months*		
Single Vision		\$10 copayment	reimbursed up to \$25
Bifocal		\$10 copayment	reimbursed up to \$35
Trifocal		\$10 copayment	reimbursed up to \$45
Lenses include factory scratch coating at no additional cost. Polycarbonate and photochromic lenses are covered for dependent children under 19 with no additional cost when received from Network Providers.			
Frames	One frame every 24 months*	\$115 allowance (You pay any amount over the allowance)	reimbursed up to \$64
Contact Lenses	Once every 24 months*		
Elective (conventional and disposable)		\$75 allowance	reimbursed up to \$75
Non-Elective		Covered in full	Covered in full
Note: Contact lenses are in lieu of eyeglass lenses. If you choose covered non-elective or elective contact lenses, no benefits will be available for covered eyeglass lenses in that benefit period.			

*from the last date of service.

Eligibility and Enrollment

Who is Eligible

Subscriber

You are eligible to be a subscriber and have coverage under this plan if you are an employee of the group and meet the group's eligibility criteria.

Dependents

You may enroll your eligible dependents for coverage under this plan. Your dependents are only eligible for coverage if they are one of the following:

- **Spouse:** Your spouse under a legally valid marriage or a common-law spouse.
- **Child:** Yours' or your spouse's child by blood or by law that is under age 26. A child is your natural or legally adopted child, stepchild, or children for whom you are the legal guardian or the proposed adoptive parent.

Your child may continue coverage beyond the above stated age limit if they are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap, and chiefly dependent on you for support and maintenance. You and the child's physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form.

Newborn and Adopted Dependent Coverage

We provide automatic coverage to a newborn child or an adopted child (under 18 years of age) for 31 days. For a newborn child coverage begins on the date of birth. For an adopted child coverage begins on the date you assume or retain a legal obligation to support the child.

You must add the newborn child or adopted child to your *plan* within 31 days for coverage to continue beyond 31 days. You must contact us to obtain the necessary forms.

Notice of Changes in Eligibility

You must tell your employer and us if there are any changes that will affect your or your *dependent's* eligibility. You must notify us within 31 days of any event that changes your or your *dependents* eligibility. This includes a change in address, a marriage, or a divorce. If you do not tell us about a change in eligibility, it does not obligate us to pay for vision care.

How to Enroll Your Dependents for Coverage

Open Enrollment

At least once a year your employer will hold an open enrollment period. During the open enrollment period your eligible *dependents* can enroll for coverage. You may only enroll for coverage during the open enrollment period or during a special enrollment period. See below for more information on special enrollment.

Special Enrollment

There may be times when your or your *dependents* can enroll for coverage outside of the open enrollment period. We allow this when there is a change in a dependent status, a court order, or an involuntary loss of other group coverage.

- **Involuntary Loss of Other Group Coverage** – If you or your dependents did not enroll during the open enrollment period because of other vision coverage, you may enroll when that coverage ends. You or your dependents must tell us within 31 days after the other coverage ends to enroll.
- **Change in Dependent Status** – If you have a new dependent due to a qualifying event, you may enroll your dependent for coverage. A qualifying event is marriage, a civil union, the birth of a child, or a child placed for adoption. You must enroll your dependent within 31 days of the qualifying event.
- **Qualified Medical Child Support Order** – If you are required by a Qualified Medical Child Support Order or other court order to provide coverage to a child, you can enroll the child at any time. You do not have to wait until your employer's open enrollment period.

Notice of Changes in Eligibility

You must tell your employer and us if there are any changes that will affect your or your *dependent's* eligibility. You must notify us within 31 days of any event that changes your or your *dependents* eligibility. This includes a change in address, a marriage, or a divorce. If you do not tell us about a change in eligibility, it does not obligate us to pay for vision care.

Your Effective Date

Your effective date and enrollment requirements are described in the group contract. See your human resources or benefits department for more information on your specific effective date under this plan.

TERMINATION, CONTINUATION AND CONVERSION

Termination

This section explains how your coverage may end and your rights regarding reinstatement. Unless otherwise stated in this section, any notice of cancellation or nonrenewal will be delivered to your group.

If Your Group Cancels Coverage

Your coverage will end if your *group* cancels coverage or on the date the *group contract* between us and the *group* ends.

Non-Renewal

We may cancel the *group contract* by not renewing if membership in your *group* falls below the minimum number of subscribers we require. We will notify your group at least 30 days before the coverage ends.

If You Cancel Your Coverage.

If you want to cancel your or your *dependent's* coverage you need to tell us in writing. You may provide the date you would like to cancel your coverage. If you do not provide a cancellation date we will cancel your *plan* on the first day of the next month. We will send you notice of your cancellation date.

If You or Your Dependents Are No Longer Eligible

Coverage will end when you and/or your *dependents* no longer meet the eligibility requirements as outline under the section Eligibility and Enrollment. If you are no longer a *subscriber* under this certificate, coverage for your *dependents* will also end.

Misrepresentation of Material Fact

If you make a misrepresentation of material fact in writing on your enrollment application, and the fact misrepresented is something that would have caused us to deny your application when it was initially submitted, your *plan* may be cancelled.

Fraud

If you or your *dependents* knowingly engage in any fraud or misuse of the benefits in this booklet, we will cancel your coverage. Cancellation will be effective 31 days after the notice of cancellation is mailed.

We will also cancel this coverage if your *group* or your *group's* representative knowingly engages in any fraud or misuse of the benefits in this booklet.

If Your Group Does Not Pay the Premium

We must receive the premium no later than the end of the grace period for your coverage to remain in force. Your *group* has a 31 day grace period. If your *group* does not pay your premium by the end of this grace period we may cancel your coverage. We will send your *group* written notice of cancellation at least 14 days before the coverage ends. See the "Reinstatement" provision later in this section for information on how to reinstate coverage that has been cancelled due to nonpayment of premiums.

If You Fail to Pay the Premium. If you fail to pay or fail to make satisfactory arrangements with the Group to pay your portion of the Premium, coverage will end as of the last date for which Premium was paid.

We Cease to Offer This Coverage

If we cease to offer coverage in the small group market, we will notify your *group* at least 30 days before this coverage ends.

Reinstatement

If coverage under this *plan* lapses because the premium has not been paid within the time allowed, you will not be reinstated automatically. Re-application may be necessary, unless the lapse was from an inadvertent clerical error. Your coverage will not be adversely affected due to the group's clerical error.

Within 90 days after cancellation due to nonpayment of premium, you or a person designated to act on your behalf, or a dependent of yours covered under this certificate, may request reinstatement on the basis that the loss of coverage was a result of your cognitive impairment or functional capacity. We will reinstate the same coverage you had prior to the cancellation or the coverage you would have been entitled to if the coverage had not been cancelled, subject to the same terms, conditions, limitations and exclusions. Before we reinstate your coverage, you must pay the premium due from the date of cancellation through the month in which we bill you. The premium will be the same amount it would have been if the coverage had remained in force.

Continuation

COBRA Continuation of Coverage

Your employer is subject to COBRA if they have more than 20 employees. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your dependents for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.
- You lose coverage because your employment ends. (For voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your dependents for 29 months for the following events:

- You or your dependent was disabled when coverage ended or within 60 days after the coverage ended. However, you or your dependent must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your dependents for 36 months for the following events:

- Your death.
- You become eligible for Medicare in the 18 months before an event listed above.
- You divorce or separate from your spouse.
- Your dependent children no longer qualify as dependents.

You must notify your employer within 60 days if you or your dependents wish to continue coverage under COBRA after an event. Once notified, your employer will provide the information on how coverage under COBRA may continue, and must give us notice within 30 days of the event that you wish to continue coverage.

This is just a summary of your continuation of coverage rights. Contact your employer for more information.

How Continuation of Coverage Ends

Your continuation of coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

- The Group Contract between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium.
- You tell us in writing to cancel your coverage.

- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for COBRA if the following occurs:

- You are eligible for coverage with another group. However, if your COBRA plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.
- You get Medicare
- Your coverage was extended to 29 months and you are now no longer disabled.

Continuation of Coverage Due to Military Service

In the event you are no longer actively at work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your dependents, if any, under this certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Military service means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty for training, and full-time National Guard duty.

If you elect to continue to cover yourself and your dependents under this *certificate* during your absence, you must pay any required premium amount for the coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time that is less than 31 days, you may not be required to pay more than your normal portion of the premium for this continuation of coverage. Continuation under this provision will be for a period of 24 months, beginning on the first day of your absence from work or the day after the date on which you fail to apply for or return to a position of employment.

Regardless of whether you continue your coverage under this provision, you may still be reinstated for coverage under this *certificate* upon your return to employment after your military service.

Conversion Coverage

Conversion is not available under this *plan*.

Your Vision Benefits

The following services or supplies are covered subject to our Conditions of Service. We will only pay for vision care that is listed in this section. We will not pay for vision care listed in the Exclusions section.

Note: Your out-of-pocket costs may be higher if you receive vision care from a *non-network provider*. See your Schedule of Benefits for more information on your allowances and your benefit frequencies. For help finding a *network provider*, contact us at the phone number under the "Contact Us" section at the beginning of this booklet or by visiting our website at www.empireblue.com.

Eye Exam

Your *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

LIMITATIONS - Coverage is NOT provided for:

- **Non-licensed vision care providers.** Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Eye surgery.** Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Missed or cancelled appointments.** We will not pay for appointments a member has missed or cancelled.

Eyeglass Lenses

You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating at no additional cost. Your dependent children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost.

Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)

Frames

You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance, then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

LIMITATIONS - Coverage is NOT provided for:

- **Sunglasses.** Sunglass lenses or accompanying frames.
- **Non-prescription lenses.** Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- **Lost or broken lenses or frames.** Any lost or broken lenses or frames, unless you have reached a new benefit period.

Elective Contact Lenses

Elective contact lenses are contacts that are not medically necessary. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.

Non-Elective Contact Lenses

Your provider may prescribe non-elective contact lenses for certain conditions of the eyes. Non-elective contact lenses are in lieu of your eyeglass lenses benefit and are covered for the following diagnoses:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Benefits.

Important Note: We will not reimburse for non-elective contact lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

LIMITATIONS - Coverage is NOT provided for:

- **Premium contact lenses fittings.** This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Orthoptics.** Orthoptics or vision training and any associated supplemental testing.
- **Services or supplies combined with discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement.

LIMITATIONS- Coverage is NOT provided for:

- **Not specifically listed.** Services not listed in the "Your Vision Benefits" section of this *certificate*.
- **Hospital care.** Inpatient or outpatient hospital vision care.
- **Cosmetic Options.** Cosmetic lens options not specifically listed
- **Excess amounts.** Any amounts in excess of the maximum benefits stated in this *certificate*.

What is Not Covered

We will not pay for services incurred for, or in connection with, any of the items below.

- **Services of relatives.** Professional services or supplies received from a person who is a member of your immediate family.
- **Voluntary payment.** Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Government treatment.** Any treatment provided in a government hospital, or provided under Medicare or other governmental program (except Medicaid).
- **Work-related.** Treatment benefited through any State or Federal workers' compensation, employers' liability or occupational disease law.

How to Submit a Claim

You are responsible for getting claims filed after you receive vision care. However, if you receive vision care from a *participating provider* they will typically file claims on your behalf.

Notice of Claim

After you receive vision care you will need to contact us, either by phone or mail, within 20 days of your vision care so we can provide you claim forms for filing. If you are unable to contact us within 20 days, you should contact us as soon as possible. We will provide claim forms within 15 days after you notify us for you to file. If you do not receive a claim form within 15 days after you request one, you may send us another form of proof of loss, such as an itemized bill instead. The itemized bill should include all of the following:

- the date of service;
- the patient's name, date of birth, and identification number;
- the type and place of service;
- your signature and the *provider's* signature.

Proof of Loss

We must receive your proof of loss within 120 days from the date you had your vision care. If it is not reasonably possible to send the claim within this time, we will not void or reduce your claim. However, you must send it as soon as is reasonably possible.

Please send claims and itemized bills to the following address:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

General Provisions

Entire contract - changes: Your *plan* is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application, and any amendments. In addition, your employer has the *group contract* and the group master application, which are also part of the terms of your *plan*. All statements contained in any application for coverage shall be deemed representations and not warranties. An executive officer must endorse any change that we issue for it to be valid. No agent has authority to change this *plan* or to waive any of its provisions.

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.

Time of payment of claims: We will pay claims immediately once we receive written proof of your claim as outlined under our claims procedure.

Payment of claims: We will pay claims directly to providers if they have an assignment of benefits on file. If the provider does not have an assignment of benefits on file then we will pay claims to you. If you pass away, we will pay claims to your designated beneficiary or to your estate if there is no assignment of benefits.

Vision examinations: We may have you examined as reasonably needed while we are deciding to pay a claim.

Change of beneficiary: You have the right to choose your own beneficiary.

Independent Contractors: Providers are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from them.

Right of Recovery: When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan.

Legal Actions: No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of two years after the time written proof of loss is required to be furnished.

Coordination of Benefits: We consider this *plan* primary in all circumstances.

Modifications. We have the right to amend, modify, or terminate any of the provisions of this *plan*. We will notify the group in writing at least 30 days before the change takes effect. If there will be a change to the premium, we will notify the group in writing at least 60 days before the change takes effect.

Renewal. Upon your group's contract anniversary date, this coverage will renew at the option of the group, as long as all premiums are paid.

GRIEVANCE AND APPEALS

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.

Filing a Grievance. You can contact us by phone at (866) 723-0515 or in writing to file a grievance. You or a person you authorize has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgement letter within 15 business days. The acknowledgement 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.

Grievance Determination. Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certificated or registered health care professional will look into it. We will decide the grievance and notify you within the following timeframes:

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

Grievance Appeals. If you are not satisfied with the resolution of your grievance, you or you authorized representative may file an appeal by phone or in writing. You have up to 60 business days from receipt of the grievance determination to file an appeal.

When we receive your appeal, we will mail an acknowledgement letter within 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 time frames:

Expedited/Urgent Grievances:	The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of your appeal.
Post-Service Grievances: (A claim for a service or a	30 calendar days of receipt of your appeal.

treatment that has already been provided.)

All Other Grievances:
(that are not in relation to a claim or request for service.)

30 business days of receipt of all necessary information to make a determination.

If you remain dissatisfied with our appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:

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

Definitions

The meanings of key terms used in this *certificate* are shown below. Whenever any of the key terms shown below appear, they will appear in italicized letters. When any of the terms below are italicized in your *certificate*, you should refer to this section.

Benefit period is a calendar year, which is a 12 month period starting on January 1st at 12:01 a.m. Eastern Standard Time.

Certificate is this booklet, which is a summary of your *plan's* coverage.

Copay is a fixed dollar amount that you are responsible to pay.

Covered service is a vision service that is listed in the "Your Vision Benefits" section of this *certificate*.

Dependent is a person of the *subscriber's* family who is eligible for coverage under the *plan* as described in the Eligibility section of this *certificate*.

Effective date is the date your coverage begins.

Group (employer) is the person, company, corporation, partnership or other entity which has entered into a contract with us to provide the benefits of the *plan*.

Group contract is the contract issued by us to the group as a means of providing certain benefits to the *group's* employees and eligible *dependents*.

Member is any person enrolled for coverage under this *plan* (a *subscriber's* or *dependent*).

Network provider is a provider who has not entered into a contractual agreement with us for the network associated with this *plan*.

Non-network provider is a provider who has entered into a contractual agreement with us for the network associated with this *plan*. They also accept our payment plus your cost-share as payment in full for *covered services*.

Plan is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, any amendments, the *group contract*, and the group master application.

Subscriber is the employee that has enrolled and been accepted for coverage under this *plan*.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Bengali

বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish

רופט די מעמבער באדינונגען נומער אויף אייער איר האט די רעכט צו באקומען דעם אינפארמאציע און היילפט אין אייער שפראך בחינם. קארטל פאר היילף (TTY/TDD:711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for our health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber or your plan for payment purposes.
- We may share PHI with your health care providers so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with care management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may use your publicly and/or commercially available data about you to provide you with information about available health plan benefits and services.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit empireblue.com/health-insurance/about-us/privacy for more information.

Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

You may have an opportunity to receive email communications involving limited PHI such as welcome materials. We will obtain your consent before initiating these email communications.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice also require your written OK. You always have the right to revoke any written OK you provide,

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities.
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents).
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety.
- Special government functions, for Worker's Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity and Language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information in various health care operations, which include identifying health care disparities, developing care management programs and educational materials and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through email. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent to use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Empire BlueCross BlueShield (Empire), Empire does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Empire does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not pre-empt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be contacted by phone, just let the caller know, and we won't reach out this way anymore or call 1-844-203-3796 to add your phone number to our Do Not Call list.

Complaints

If you think we have not protected your privacy, you can file a complaint with us at the Customer Service phone number printed on your ID card. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services, Office for Civil Rights by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint, or talk with you about privacy issues.

COPIES AND CHANGES

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

STATE NOTICE OF PRIVACY PRACTICES

As mention in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company - without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.