Dear Oxford member,

Welcome, and thank you for selecting an Oxford plan. Your satisfaction is important to us; we want your health care benefits experience to be a positive one. As an Oxford member you have access to a host of resources, programs and tools—all meant to help you use your benefits, take charge of your health and get the most out of your plan. Following are highlights of several key plan features:

Install the UnitedHealthcare® app for easy access to your health plan.

Network access

We have a large network of providers located throughout the Oxford tri-state service area.[1] Using network doctors, mental health professionals, hospitals, clinics, and laboratories typically saves you money. Most Oxford plans also include out-of-area coverage through UnitedHealthcare national networks if you live or travel outside the Oxford service area.[2] Use the provider search tool on the member website, **myuhc.com®**, or through the UnitedHealthcare® app to look up network providers for your plan. You can also call us for assistance at the phone number on your health plan ID card.

Your personal member website and app

A self-service health plan member website, **myuhc.com**, allows you convenient, around-the-clock access to information about your health benefits, the ability to request a health plan ID card, locate a participating provider, update your personal information, and more. Register on the website and download the UnitedHealthcare app for help staying connected to your benefits.

UnitedHealthcare Rewards[3]

You can earn up to $300 in a plan year for a variety of healthy actions — including things you may already be doing, like tracking your steps or getting a biometric screening. Your total earnings potential may vary based on your health plan. Find out more by signing in to the UnitedHealthcare app, select the Me tab and then Rewards. Or sign in to **myuhc.com** > **Rewards.**

Sweat Equity® Program

This wellness program offers you reimbursement toward your cardio-based physical fitness expenses—up to $200 two times per plan year—after meeting the program requirements.[4]

Cancer support

Led by experienced cancer nurses with assistance from a board-certified medical oncologist, a hematologist, and other doctors, as well as social workers, this program offers compassionate guidance and answers for you or a family member who's faced with cancer. Call **1-866-936-6002** for support.[5]

Behavioral health solutions

For life's challenges, support is here. You have access to a 24/7 substance use help line, as well as a website dedicated to mental health and substance use resources. Call the helpline at **1-855-780-5955** 24 hours a day, 7 days a week.

continued...

Centers of Excellence

These providers are identified for meeting our quality assessment criteria and being in good standing with us and national accreditations. They have demonstrated their ability to deliver cost-effective care for complex medical conditions and other services and procedures.[6]

More information

If you have questions about this information or your coverage, or if you want to learn more about available programs and resources, sign in to **myuhc.com** or call us at the toll-free number on your health plan ID card.

Wishing you the best of health,

The Oxford Team

[1] The Oxford tri-state area includes Connecticut, New Jersey, and certain New York counties (Ulster, Sullivan, Dutchess, Orange, Putnam, Rockland, Westchester, Bronx, New York, Queens, Kings, Richmond, Nassau, and Suffolk). Network access may vary by plan.

[2] National network access may vary by plan and may not be available for all groups, including groups with an Oxford Metro Network® plan. Network participation subject to change.

[3] UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

[4] Reimbursement is generally limited to the lesser of $200 (subscriber)/$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per 6-month period, but the reimbursement may vary by plan. Refer to your benefits documents or check with your benefits administrator to find out how much you may be reimbursed. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.

[5] The Cancer Support program **should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.** The information provided through this service is for informational purposes only and provided as part of your health plan. The nurse cannot diagnose problems or recommend treatment and is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. This nurse support service is not an insurance program and may be discontinued at any time.

[6] The Centers of Excellence (COE) program providers and medical centers are independent contractors who render care and treatment to health plan members. The COE program does not provide direct health care services or practice medicine, and the COE providers and medical centers are solely responsible for medical judgments and related treatments. The COE program is not liable for any act or omission, including negligence, committed by any independent contracted health care professional or medical center.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card 8 a.m. – 6 p.m. ET, Monday – Friday. TTY users can dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación. 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務. 請撥打會員卡所列的免付費會員電話號碼. 알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization's rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.
- Sign in to myuhc.com, or call us when you have a question about your eligibility, benefits, claims and more.
- Sign in to myuhc.com or call us before receiving services to verify that your doctor or health care professional participates in the UnitedHealthcare network.

UnitedHealthcare® Oxford

9800969.0 9/19

This is Your

PREFERRED PROVIDER ORGANIZATION

CERTIFICATE OF COVERAGE

Issued by

Oxford Health Insurance, Inc.

One Penn Plaza

8th Floor

New York, NY 10119

1-800-444-6222

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Policy between Oxford Health Insurance, Inc. (hereinafter referred to as "We", "Us" or "Our") and the Group. 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 Our Freedom Network in Our New York Service Area, New Jersey and Connecticut. When you are outside of this Service Area, in-network benefits also apply when You receive Covered Services from Participating Providers in Our affiliate's Choice Network. 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. Some Covered Services, such as preventive care for adults, are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Certificate for more information.

Depending on the geographic area and the service You receive, You may have access through our Shared Savings Program to Non-Participating Providers who have agreed to discount their billed charges for Covered Services. Refer to the Definitions and Cost-Sharing Expenses and Allowed Amount sections of this Certificate for details about how the Shared Savings Program applies.

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

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

Junior Harewood

President

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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.

Air Ambulance: medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in CFR 414.605.

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.

Amendment: any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

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

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

Certificate: This Certificate issued by Oxford Health Insurance, 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 New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

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

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

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

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

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

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

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

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

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

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

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

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

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. 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.

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

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

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

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

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

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before 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.

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

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at www.myuhc.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: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, 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.

Preimplantation Genetic Testing (PGT): a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

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. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating Physician 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. 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. A Referral is not required but is needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this Certificate.

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.

Rider: - any attached written description of additional Covered Health Care Services not described in this Certificate. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that if you have Benefits for Outpatient Prescription Drugs, while presented in Rider format, they are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

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

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Bronx, Duchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester.

Shared Savings Program: A program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Non-Participating Provider and a third party vendor. When this program applies, the Non-Participating Provider's billed charges will be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the Provider.
- The median amount negotiated with Network Providers for the same or similar service.

In this case, the Non-Participating Provider may bill You for the difference between the billed amount and the rate determined by Us. If this happens, You should call the telephone number shown on Your ID card for assistance with resolving that issue. Shared Savings Program Providers are not Participating Providers and are not credentialed by Us.

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 amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

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

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

Us, We, Our: Oxford Health Insurance, 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 Policy from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

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

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

C. **Participating Providers.** To find out if a Provider is a Participating Provider:

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

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

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

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

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

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

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

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal

medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

E. **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 Oxford Freedom Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

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

You may change Your PCP by selecting a new Provider from Our roster and either contacting Us at the customer service number on Your ID card or by accessing Our website at www.myuhc.com. This can be done at any time and the change will be effective the first day of the month following the date of the change.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our Network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

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

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

H. **Preauthorization Procedure.** If You seek Coverage for out-of-network services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least five (5) business days 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 five (5) business days 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 (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport) are rendered for a non-Emergency Condition.

I. **Failure to Seek Preauthorization.** If You fail to seek Our Preauthorization for benefits subject to this section, We will pay an amount of $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining 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. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

J. **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.

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

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

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

surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External 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.

L. **Protection from Surprise Bills.**

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

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

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

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

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

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

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

M. **Delivery of Covered Services Using Telehealth.** If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, by a Participating Provider to deliver

Covered Services to You while Your location is different than Your Provider's location. Telehealth does not include virtual visits provided by a designated virtual network provider.

Benefits are also provided for remote physiologic monitoring. Benefits are provided to the same extent as an in-person service under any applicable benefit category in this section unless otherwise specified in the Schedule of Benefits. For purposes of this benefit, "remote physiologic monitoring" means the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified Health Care Professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more remote physiologic monitoring devices. Remote physiologic monitoring must be ordered by a licensed Physician or other qualified Health Care Professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote physiologic monitoring may not be used while the patient is inpatient at a Hospital or other Facility. Use of multiple devices must be coordinated by one Physician

N. **Care Management.** Care 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 care management program to help meet their health-related needs.

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our care 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.

O. **Important Telephone Numbers and Addresses.**

- **CLAIMS**
  - Refer to the address on Your ID card

    (Submit claim forms to this address.)
  - www.myuhc.com

    (Submit electronic claim forms to this e-mail address.)
- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**

  Call the number on Your ID card
- **SURPRISE BILL CERTIFICATION FORM**

  Refer to the address on Your ID card

  (Submit surprise bill certification forms to this address.)
- **MEDICAL EMERGENCIES AND URGENT CARE**

Call the number on Your ID card

Monday - Friday 8:00 a.m. - 6:00 p.m.

Evenings, Weekends and Holidays

- **MEMBER SERVICES**

  Call the number on Your ID card

  (Member Services Representatives are available Monday – Friday 8:00 a.m. – 6:00 p.m.)

- **PREAUTHORIZATION**

  Call the number on Your ID card

- **BEHAVIORAL HEALTH SERVICES**

  Call the number on Your ID card

- **OUR WEBSITE**

  www.myuhc.com

SECTION III - Access to Care and Transitional Care

A. **Authorization to a Non-Participating Provider.**

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

B. **When Your Provider Leaves the Network.**

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

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

C. **New Members In a Course of Treatment.**

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

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

SECTION IV - Cost-Sharing Expenses and Allowed Amount

A. **Deductible.**

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

You have a separate In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services do not apply toward Your In-Network Deductible. Copayment and Coinsurance for in-network services do 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.**

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

Prescription Drug Deductible. Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Prescription Drugs during each Plan Year before We provide Coverage. Copayments and Coinsurance for out-of-network services do not apply toward Your In-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, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network 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, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network 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 and Out-of-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered In-Network Services for the remainder of that Plan Year. If You have other than individual coverage, 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 Plan Year for that person. If other than individual Coverage applies, when persons in the same family covered under this Certificate have collectively met the family In-Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

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

E. **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 Plan Year 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 Plan Year. 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 Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year 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 How Your Coverage Works section of this Certificate does not apply toward Your Out-of-Network Out-of-Pocket Limit. The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

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. **Shared Savings Program:** A program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Non-Participating Provider and a third party vendor. When this program applies, the Non-Participating Provider's billed charges will be discounted. Co-insurance and any applicable deductible would still apply to the reduced charge. Our policy provisions or administrative practices may supersede the scheduled rate. This means, when contractually permitted, we may pay the lesser of the Shared Savings Program discount or an amount determined by us, such as:

- A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the Provider.
- The median amount negotiated with Network Providers for the same or similar service.

In this case, the Non-Participating Provider may bill You for the difference between the billed amount and the rate determined by Us. If this happens, You should call the telephone number

shown on Your ID card for assistance with resolving that issue. Shared Savings Program Providers are not Participating Providers and are not credentialed by Us.

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

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

Our payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

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

1. **Facilities in Our Service Area.**

   For Facilities in Our Service Area, the Allowed Amount will be:

   - 390% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount for the date(s) on which the services were rendered. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 20% of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.
   - A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
   - The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.

   If there is no amount as described above, the Allowed Amount will be:

   - 390% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount for the date(s) on which the services were rendered. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 20% of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.
   - A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
   - The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.

2. **Facilities Outside Our Service Area.**

   For Facilities outside Our Service Area, the Allowed Amount will be:

   - 390% of the Centers for Medicare and Medicaid Services Prospective Payment System amount for the date(s) on which the services were rendered. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 20% of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.

- A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
- The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.

If there is no amount for Facilities outside Our Service Area as described above, the Allowed Amount will be:

- 390% of the Centers for Medicare and Medicaid Services Prospective Payment System amount for the date(s) on which the services were rendered. In the event We are unable to price the services at the PPS rate because of insufficient claims data or there is no PPS rate, the Allowed Amount will be 20% of the average amount We have negotiated with Facilities that are Participating Providers of the same or similar type as the non-participating Facility.
- A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
- The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.

3. **For All Other Providers in Our Service Area.**

   For all other Providers in Our Service Area, the Allowed Amount will be:

   - 390% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type.
   - A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
   - The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.
   - For freestanding physical therapists, the Allowed Amount will be 70% of the published rates allowed by the Centers of Medicare and Medicaid Services for Medicare for the same or similar service.

   If there is no amount as described above for all other Providers outside Our Service Area, the Allowed Amount will be:

   - 390% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type.
   - A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
   - The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.
   - For freestanding physical therapists, the Allowed Amount will be 70% of the published rates allowed by the Centers of Medicare and Medicaid Services for Medicare for the same or similar service.

4. **For All Other Providers Outside Our Service Area.**

For all other Providers outside Our Service Area, the Allowed Amount will be:

- 390% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type.
- A rate based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers' fees and costs to deliver care.
- The amount We (or a contractor acting on Our behalf) have negotiated with the Facility.
- For freestanding physical therapists, the Allowed Amount will be 70% of the published rates allowed by the Centers of Medicare and Medicaid Services for Medicare for the same or similar service.

5. **Physician-Administered Pharmaceuticals.**

   For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

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

SECTION V - Who is Covered

A. **Who is Covered Under this Certificate.**

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate.

Your employer must have an office location in Our Service Area. You must live, work, or reside in a state in which We are authorized to deliver a Certificate. This list presently includes New York, New Jersey, Connecticut and other states outside of the New York tri-state area. If You would like to confirm if Your state is on the list, You may do so by calling the Customer Service number on Your ID card.

Members of Your family may also be covered depending on the type of coverage You selected.

B. **Types of Coverage.**

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. **Children Covered Under this Certificate.**

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Grandchildren are not covered.

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

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

D. **When Coverage Begins.**

Coverage under this Certificate will begin as follows:

If You, the Subscriber, elect coverage before becoming eligible, or within 31 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.

If You, the Subscriber, do not elect coverage upon becoming eligible, or within 31 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.

If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within 31 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 31 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.

If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 31 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 31 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 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. **Special Enrollment Periods.**

You, Your Spouse or Child can also enroll for coverage within 31 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 31 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 31 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

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

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

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

SECTION VI - Preventive Care

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

Preventive Care.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at www.myuhc.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 Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Cost-Sharing 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.myuhc.com or will be mailed to You upon request.

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

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

C. **Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. **Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.myuhc.com or will be mailed to You upon request. This benefit is not subject to Cost-Sharing when provided in

accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

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

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

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

Mammograms for the screening of breast cancer are not subject to Cost-Sharing 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 Cost-Sharing 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 Outpatient Prescription Drug Rider; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover vasectomies subject to Cost-Sharing.

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

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

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

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an

"A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. **Prostate Cancer Screening.** We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 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 Cost-Sharing when provided by a Participating Provider.

I. **Colon Cancer Screening.** We Cover colon cancer screening for Members age 45 through 75, including all colon cancer examinations and laboratory tests in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society Guidelines for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

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

SECTION VII - Ambulance and Pre-Hospital Emergency Medical Services

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

A. **Emergency Ambulance Transportation.**

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

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

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

   An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible, or Coinsurance.

   In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 70th percentile calculated using the place of pickup or the Provider's billed charges.

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

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.

D. **Payments for Air Ambulance Services.**

We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Air Ambulance service.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Air Ambulance service or an amount We have determined is reasonable for the Air Ambulance service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

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

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

SECTION VIII - Emergency Services and Urgent Care

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

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

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

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

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

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- 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 following Emergency Department Care at a non-participating Hospital at the In-Network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

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

   We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

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

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

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

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

   2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center or Physician outside Our Service Area. However, You must obtain Preauthorization from Us. Please contact Us at the number on Your ID card and You will be provided with instructions.

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

SECTION IX - Outpatient and Professional Services

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

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

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

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

D. **Chemotherapy and Immunotherapy.** We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Outpatient Prescription Drug Rider.

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

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

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

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

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

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

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

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

H. **Habilitation Services.** We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office.

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.

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 or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services or Habilitation Services benefits.

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

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:

   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

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

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

   Comprehensive infertility services include:

   - Ovulation induction and monitoring;
   - Pelvic ultrasound;

- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

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

   A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.
4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.
5. **Exclusions and Limitations.** We do not Cover:
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

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

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

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

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

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 from a Participating Provider or designated vendor. We will determine which pump is the most cost effective, whether the pump should be purchased or rented (and the duration of any rental) and the timing of the purchase or rental.

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. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

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. **Preimplantation Genetic Testing (PGT) and Related Services.** We Cover Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:

- Ovulation induction (or controlled ovarian stimulation).
- Egg retrieval, fertilization and embryo culture.
- Embryo biopsy.
- Embryo transfer.
- Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

S. **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 Outpatient Prescription Drug Rider.

T. **Retail Health Clinics.** We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses.

U. **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.

V. **Second Opinions.**

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

W. **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.

1. **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.
2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
    - For the procedure with the highest Allowed Amount; and
    - 50% of the amount We would otherwise pay for the other procedures.

X. **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.

Y. **Reconstructive Breast Surgery.** We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Z. **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.

AA. **Transplants.** We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants including CAR-T cell therapy for malignancies.

Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated as Centers of Excellence to perform these procedures.

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

We do not Cover: 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.

BB. **Virtual Visits.** In addition to providing Covered Services via telehealth, We Cover virtual visits for Covered Services that includes the diagnosis and treatment of less serious medical conditions. Virtual visits provides communication of medical information in real-time between the patient and a distant Physician or health specialist outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting Us at the telephone number on Your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology, and/or through federally compliant secure messaging applications for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual visits. The designated virtual network provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email or fax, or for services that occur within medical facilities (CMS defined originating facilities).

For purposes of this benefit, "designated virtual network provider" means a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Services through live audio with video technology or audio only.

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. **Cellular and Gene Therapy.** We Cover cellular therapy and gene therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at a Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplants.

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
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets

- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

2. **Self-Management Education.** Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:
   - By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
   - Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
   - Education will also be provided in Your home when Medically Necessary.
3. **Limitations.** The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

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 over-the-counter durable medical equipment.

   We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.
2. **Braces.** We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost

or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. **Enteral Nutrition.** Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

E. **Gender Dysphoria.** We Cover the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

F. **Hearing Aids.**

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

   Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

   Benefits are also provided for certain U.S. Food and Drug Administration (FDA) approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

   Benefits for over-the-counter hearing aids do not require any of the following:

   - A medical exam.
   - A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
   - A written prescription or other order.

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

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

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

G. **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. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the

hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

H. **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.

I. **Orthoptic Exercises and Corneal and Topographic Procedures.** We Cover orthoptic exercises for the treatment of the following conditions:

- Amblyopia for Members up to age 19. Treatment includes patching and penalization therapies.
- Convergence insufficiency.

Corneal topographic procedures for the treatment of certain conditions.

J. **Prosthetics.**

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

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

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

   We do not Cover shoe inserts.

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

   Coverage is for standard equipment only.

   We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair 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 or Referral requirements that apply to these benefits.

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

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

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

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.

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

E. **Inpatient Stay for Mastectomy Care.** We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period 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. **Habilitation Services.** We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy up to the limit reflected in Your Schedule of Benefits.

H. **Rehabilitation Services.** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy up to the limit reflected in Your Schedule of Benefits.

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

J. **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.

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

- Transplants.

L. **Limitations/Terms of Coverage.**

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

SECTION XII - Mental Health Care and Substance Use Services

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

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

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

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

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

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

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization/day treatment/high intensity outpatient program services, intensive outpatient program services and intensive behavioral therapy, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the

Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us. Outpatient services also include nutritional counseling to treat a mental health condition.

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

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

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

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

We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

iii. Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

iv. Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

v. Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this 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.

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

vii. Limitations. We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this 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.

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

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

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

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization/day treatment/high intensity outpatient program services, intensive outpatient program services, intensive behavioral therapy, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient

substance use disorder services and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

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 covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

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

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

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

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

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

SECTION XIV - 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. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address on Your ID card.

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

D. **Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. **Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

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

F. **Pre-Service Claim Determinations.** 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.

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 deny the claim in whole or in part. 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 if We deny the claim in whole or in part.

H. **Payment of Claims.** Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 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 15 days of Our determination that payment is due but no later than 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 XV - 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 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.

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

C. **Grievance Determination.** Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 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 30 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 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 calendar days of receipt of Your Appeal.

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 XVI - 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.

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

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

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

B. **Preauthorization Reviews.**

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 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 earlier of the receipt of part of the requested information or 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 and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period.

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.

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

5. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your treatment.

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

C. **Concurrent Reviews.**

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of one (1) business day of the receipt of part of the requested information or 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. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

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

5. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days 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 approved by OMH. 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.

6. **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 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your inpatient admission.

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

D. **Retrospective Reviews.** If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 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 all or part of the requested 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. **Retrospective Review of Preauthorized Services.** We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

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

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

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

G. **Reconsideration.** If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. **Utilization Review Internal Appeals.** You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone 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. **First Level Appeal.**

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 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.

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

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 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. **Full and Fair Review of an Appeal.** We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

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

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level 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 inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 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.
3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

L. **Appeal Assistance.** If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org

Website: www.communityhealthadvocates.org

SECTION XVII - External Appeal

A. **Your Right to an External Appeal.** In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment; or is an emergency service or a surprise bill (including whether the correct Cost-Sharing was applied), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

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

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

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

C. **Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

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

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation - Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the

requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

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

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

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

E. **Your Right to Appeal an Out-of-Network 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 the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that

in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 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.

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

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 XVIII - 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 XIX - 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 Last Day of Event Month which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 26 years of age.
6. For all other Dependents, the Last Day of Event Month which the Dependent ceases to be eligible.
7. The end of the month following the 30th day after the Group's provision of written notice of termination of coverage to Us; or such later termination date requested by the Group's notice.
8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. 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 Policy is terminated. If We decide to stop offering a particular class of group policies, 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 decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least 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 ceases to meet the statutory requirements to be defined as a group for the purpose of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
13. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

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

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

SECTION XX - Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Policy 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 XXI - 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 Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy 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 Policy 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 XXII - 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 Policy.** If the Group Policy 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 Our affiliated insurer UnitedHealthcare Insurance Company of New York. The coverage may not be the same as Your current coverage. If We determine that You do not reside in New York State, We may issue You or Your family members coverage on a form that We use for conversion in that state.

SECTION XXIII - General Provisions

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

2. **Assignment.** You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits or request for plan documents to any person, corporation or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Certificate to any person, corporation or other organization.

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

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

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

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

6. **Conformity with Law.** Any term of this Certificate which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

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

8. **Enrollment 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 Policy 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 Amendments, 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 contacting Us at the number on Your ID card.

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

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

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

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

18. **Notice.** Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your ID card.

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

20. **Recovery of Overpayments.** On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 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 Policy of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us or the Group as permitted by this Certificate.

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

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

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

26. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state

law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

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

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

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

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

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

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

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

33. **Who Receives Payment under this Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including

inpatient services following Emergency Department Care, pre-hospital emergency medical services, Air Ambulance services, and surprise bills.

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

35. **Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

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

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

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

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

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

    You have the right to access Our Participating Providers.

    As a Member, You should also take an active role in Your care. We encourage You to:

    - Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
    - Follow the treatment plan that You have agreed on with Your doctors or Providers;
    - Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and
    - Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

If You need more information or would like to contact Us, please go to Our website at www.myuhc.com or call Us at the number on Your ID card.

SECTION XXIV - Other Covered Services

Bleeding Disorders: a group of disorders that share the inability to form a proper blood clot. They are characterized by extended bleeding after injury, surgery, trauma or menstruation. Sometimes the bleeding is spontaneous, without a known or identifiable cause. Improper clotting can be caused by defects in blood components such as platelets and/or clotting proteins, also called clotting factors. The body produces 13 clotting factors. If any of them are defective or deficient, blood clotting is affected; a mild, moderate or severe bleeding disorder can result.

The following Covered Services for medications used to treat bleeding disorders are available only when provided by the specific participating Providers listed below:

1. **Prescription Drug Coverage for bleeding disorders provided by a Participating Hemophilia Treatment Center.**

   Bleeding disorder medications that You self-administer or is administered by a non-skilled caregiver are covered under Your Prescription Drug benefits.

   In addition, we Cover bleeding disorder medications that You self-administer or is administered by a non-skilled caregiver under Your Medical Benefits when it is dispensed by a designated Participating Hemophilia Treatment Center as part of Your written treatment plan. A "Hemophilia Treatment Center" (HTC) means a unique federally designated entity that specializes in comprehensive care for pediatric and adult individuals with bleeding disorders.

   Your Cost-Sharing for medications prescribed to treat a bleeding disorder when dispensed by an HTC is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefit section of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Certificate.

2. **Non-Emergent Home Health Care - Assisted Administration of Bleeding Disorders Medications.** In addition to the Home Health Care Benefits available under Your Certificate, We will Cover non-emergent administration of medications prescribed to treat a bleeding disorder in Your home when provided by a Participating Home Health Agency certified or licensed by the appropriate state agency. This additional Home Health Care benefit covers both the medications prescribed to treat a bleeding disorder and the administration services when assisted administration is medically necessary. Coverage will be provided in lieu of receiving medically necessary Covered assisted-administration service from Your Physician or another health practitioner in an office or out-patient setting.

   Any visits for assisted administration of medications prescribed to treat a bleed disorder in Your home count towards Your Home Health Care visit limit. Your Cost-Sharing and definition of a visit in the Home Health Care Benefits shall apply to these additional services. See Your Schedule of Benefits and Home Health Care benefit for more information. Please note this Covered Service only provides Coverage for assisted administration of medications prescribed to treat a bleeding disorder. It does not Cover medications prescribed to treat a bleeding disorder that You self-administer or that is administered by a non-skilled caregiver.

3. **Preauthorization.** The Covered Services covered under this Section require Preauthorization. Your Provider must call Us or Our vendor at the number indicated on Your ID card.

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

4. **Exclusions and limitations.** Except as expressly modified by this Section, all of the exclusions and limitations of the Certificate apply to the Covered Service under this Section.

5. **Controlling Policy.** All of the terms, conditions, limitations, and exclusions of Your Certificate shall also apply to this Section except where specifically changed by this Section.

Section XXV - Schedule of Benefits

Oxford Health Insurance, Inc

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Payment Term and Description	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**
Medical Deductible			
Individual	None	None	$2,000
Family	None	None	$4,000
The amount You pay for Covered Services per Plan Year before You are eligible to receive Out-of-Network Benefits. The Deductible applies to Covered Services under the Policy as indicated in this Schedule of Benefits, including Covered Services provided under the Outpatient Prescription Drug Rider. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Deductible. The Deductible for Preferred Provider and Participating Provider benefits includes the amount you pay for both Participating and Non-Participating benefits for outpatient prescription drugs provided under the Outpatient Prescription Drug Rider. The amount that is applied to the Deductible is calculated on the basis of the Allowed Amount. The Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear in the Certificate of Coverage.			
Prescription Drug Deductible			
• **Tier 1**	No Prescription Drug Deductible.	No Prescription Drug Deductible.	Non-Participating Provider services are not Covered and You pay the full cost
• **Tier 2**	$100 per Member.	$100 per Member.	Non-Participating Provider services are not Covered and You pay the full cost
• **Tier 3**	$100 per Member.	$100 per Member.	Non-Participating Provider services are not Covered and You pay the

			full cost
The amount You pay for Covered Tier 2 and Tier 3 Prescription Drugs at a Participating Pharmacy in a Plan Year before We begin paying for Prescription Drug Products. Benefits for Prescription Drugs on the List of Preventive Medications are not subject to payment of the Prescription Drug Deductible. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Prescription Drug Deductible. Benefits for Prescription Drugs on the list of zero cost-sharing medications are not subject to payment of the Prescription Drug Deductible unless required by state or federal law. Any amount You pay that is applied to the Prescription Drug Deductible in the last quarter of the previous Plan Year will be carried over and applied to the current Prescription Drug Deductible. When a Member was previously Covered under a group policy that was replaced by the Group Policy, any amount already applied to that prescription drug deductible provision of the prior policy will apply to the Prescription Drug Deductible provision under the Policy. When the Group changes from a calendar year to a Policy year plan, any amount You pay for Prescription Drug expenses in the last three months of the previous calendar year that is applied to the previous Prescription Drug Deductible, will be rolled over and applied to the current Policy year Prescription Drug Deductible. This roll-over feature applies only to the first Policy year.			
Out-of-Pocket Limit			
Individual Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.	$2,500 $5,000	$2,500 $5,000	$4,000 $8,000 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.
The maximum You pay per Plan Year for the Deductible, Copayments or Coinsurance. Once You reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Services under the Policy as indicated in this Schedule of Benefits, including Covered Services provided under the Outpatient Prescription Drug Rider. The Out-of-Pocket Limit for Preferred Provider and Participating Provider benefits includes the amount you pay for both Participating and Non-Participating Provider benefits for outpatient prescription drug products provided under the Outpatient Prescription Drug Rider. Details about the way in which Allowed Amounts are determined appear in the Certificate of Coverage.			

Office Visits	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)				
	$25 Copayment per visit not subject to Deductible	$25 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)				
	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

Preventive Care	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Well Child Visits and Immunizations*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Adult Immunizations*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Routine Gynecological Services/Well Woman Exams*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Sterilization				

Preventive Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Procedures for Women*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Vasectomy				
	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Bone Density Testing*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Prostate Cancer Screening				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Colon Cancer Screening*				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
All other preventive services required by USPSTF and HRSA				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preventive Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
***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 & Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	20% Coinsurance after Deductible	See benefit for description

Emergency Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)				
Allowed Amounts for ground and Air Ambulance transport provided by a Non-Participating Provider will be determined as described in Section IV - Cost-Sharing Expenses and Allowed Amount in this Certificate.	Ground Ambulance Covered in full not subject to Deductible	Ground Ambulance Covered in full not subject to Deductible	Ground Ambulance Same as Participating Provider	See benefit for description
	Air Ambulance Covered in full not subject to Deductible	Air Ambulance Covered in full not subject to Deductible	Air Ambulance Same as Participating Provider	
Non-Emergency Ambulance Services				
Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for Air Ambulance transport provided by a Non-Participating Provider will be determined as described in Section IV - Cost-Sharing Expenses and Allowed Amount in this Certificate. **Preauthorization Required**	Ground Ambulance Covered in full not subject to Deductible	Ground Ambulance Covered in full not subject to Deductible	Ground Ambulance 20% Coinsurance after Deductible	See benefit for description
	Air Ambulance Covered in full not subject to Deductible	Air Ambulance Covered in full not subject to Deductible	Air Ambulance Same as Participating Provider	
Emergency Department				

Emergency Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Copayment waived if admitted to Hospital. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. **Note:** If You are confined in a Non-Participating Hospital after You receive outpatient Emergency Care Services, You must notify Us within one business day or on the same day of admission or as soon as reasonably possible. We may elect to transfer You to a Participating Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Participating Hospital after the date We decide a transfer is medically appropriate, benefits will not be provided. Allowed Amounts for Emergency Services provided by a Non-Participating Provider will be determined as described in Section IV - Cost-Sharing Expenses and Allowed Amount of the Certificate.	$150 Copayment per visit not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$150 Copayment per visit not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Same as Participating Provider Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center				
Copayments/Coinsurance and any Deductible for the following services apply when the Covered Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under Diagnostic Testing, Laboratory Procedures and Diagnostic Radiology Services. • Major diagnostic and nuclear medicine described under	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

Emergency Care	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services. • Outpatient prescription drugs described under Prescription Drugs Administered in Office or Outpatient Facilities • Outpatient surgery procedures described under Surgical Services. • Outpatient therapeutic procedures described under Therapeutic Radiology Services.				

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services				
• Performed in a Specialist Office	$40 Copayment per service not subject to Deductible	$40 Copayment per service not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Allergy Testing and Treatment				
• Performed in a PCP Office	$25 Copayment per visit not subject to Deductible	$25 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office **Preauthorization Required**	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	
Ambulatory Surgical				

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Center Facility Fee				
Preauthorization Required	$250 Copayment per visit not subject to Deductible	$250 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation				
• Performed in a Specialist Office	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Inpatient Hospital Services **Preauthorization Required**	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy and Immunotherapy				
• Performed in a PCP Office	Covered in full not subject to	Covered in full not subject to	20% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
	Deductible	Deductible		
• Performed in a Specialist Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Chiropractic Services				
Preauthorization Required	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Clinical Trials				
Preauthorization Required	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description Depending upon the Covered Service, benefit limits are the same as those stated under the specific benefit category in this Schedule of Benefits.
Diagnostic Testing				
• Performed in a PCP Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
• Performed in a Specialist Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Dialysis				
• Performed in a PCP Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider.
• Performed in a Freestanding Center	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit description for more information.
• Performed as Outpatient Hospital Services	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Preauthorization Required				
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)				
Preauthorization Required	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Any combination of physical therapy, occupational therapy and speech therapy is limited to 90 visits per year.
Home Health Care				
Preauthorization Required	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Infertility Services				
Preauthorization Required	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and in the Outpatient Prescription Drug Rider.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and in the Outpatient Prescription Drug Rider.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and in the Outpatient Prescription Drug Rider.	See benefit for description Limited to three (3) cycles of IVF per lifetime

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy				
• Performed in a PCP Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Home Infusion Therapy **Preauthorization Required**	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Home infusion counts toward home health care visit limits
Inpatient Medical Visits				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy				
• Abortion Services	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Laboratory Procedures				
• Performed in a	Covered in full not subject to	$25 Copayment per service not	Non-Participating Provider services	See benefit for

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
PCP Office	Deductible	subject to Deductible	are not Covered and You pay the full cost	description
• Performed in a Specialist Office	Covered in full not subject to Deductible	$40 Copayment per service not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	Covered in full not subject to Deductible	$60 Copayment per service not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	$60 Copayment per service not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care				
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Prenatal Care that is not provided in accordance with the	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Diagnostic	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Diagnostic	20% Coinsurance after Deductible	

Professional Services and Outpatient Care	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
comprehensive guidelines supported by USPSTF and HRSA	Radiology Services: Laboratory Procedures and Diagnostic Testing)	Radiology Services: Laboratory Procedures and Diagnostic Testing)		
• Inpatient Hospital Services and Birthing Center	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	20% Coinsurance after Deductible	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies Including Breast Pumps	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services and breast pump**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge				
Preauthorization Required	$250 Copayment per visit not subject to Deductible	$250 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Preadmission				

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Testing				
Preauthorization Required	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	20% Coinsurance after Deductible	See benefit for description
Preimplantation Genetic Testing (PGT) and Related Services				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Benefit limits for related services will be the same as, and combined with, those stated under Infertility Services. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes benefits for ovarian stimulation medications provided under Outpatient Prescription Drug Rider. Benefits for related

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
				services are limited to three Advanced Infertility Services procedures during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.
Prescription Drugs Administered in Office or Outpatient Facilities				
• Performed in a PCP Office	$25 Copayment per Prescription Drug not subject to Deductible	$25 Copayment per Prescription Drug not subject to Deductible	20% Coinsurance after Deductible	See benefit for description The following supply limits apply: • As written by the Provider, up to a consecutive 31-day supply of a Prescription Drug, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Prescription Drug is packaged or

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
				designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.
• Performed in a Specialist Office	$40 Copayment per Prescription Drug not subject to Deductible	$40 Copayment per Prescription Drug not subject to Deductible	20% Coinsurance after Deductible	
• Performed in Outpatient Facilities **Preauthorization Required**	$250 Copayment per Prescription Drug not subject to Deductible	$250 Copayment per Prescription Drug not subject to Deductible	20% Coinsurance after Deductible	
Diagnostic Radiology Services				
• Performed in a PCP Office	$25 Copayment per service not subject to Deductible	$25 Copayment per service not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$40 Copayment per treatment not subject to Deductible	$40 Copayment per treatment not subject to Deductible	20% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Therapeutic Radiology Services				
• Performed in a Specialist Office	$40 Copayment per treatment not subject to Deductible	$40 Copayment per treatment not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)				
Preauthorization Required	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Limited per year as follows:

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
				• 90 visits for any combination of physical therapy, occupational therapy and speech therapy.
Retail Health Care Clinic				
	$25 Copayment per visit not subject to Deductible	$25 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Second Opinions on the Diagnosis of Cancer, Surgery and Other				
	$25 Copayment per visit for a Primary Care Physician office visit not subject to Deductible or $40 per visit for a Specialist office visit not subject to Deductible	$25 Copayment per visit for a Primary Care Physician office visit not subject to Deductible or $40 per visit for a Specialist office visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Covered in full for second or third opinions requested by Us. If You obtain a second opinion for a diagnosis of cancer from a Non-Participating Provider, it will be Covered as an In-Network benefit.
Surgical Services (including Oral Surgery;				

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery)				
• Inpatient Hospital Surgery	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Outpatient Hospital Surgery	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Office Surgery **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Virtual Visits				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost.	See benefit for description Benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting us at www.myuhc.com or the telephone number on your ID

Professional Services and Outpatient Care	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
				card.

Additional Services, Equipment and Devices	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Cellular and Gene Therapy				
Preauthorization Required	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education				
• Diabetic Equipment, Supplies and Insulin (30-day supply)	Depending upon where the Covered Service is provided, Benefits for diabetes equipment, supplies and insulin will be the same as those stated under each Covered Service category in this Schedule of Benefits and in the Outpatient Prescription Drug Rider but not more than $100 in Cost-Sharing (including before the Deductible) for a 30-day supply for an insulin drug.	Depending upon where the Covered Service is provided, Benefits for diabetes equipment, supplies and insulin will be the same as those stated under each Covered Service category in this Schedule of Benefits and in the Outpatient Prescription Drug Rider but not more than $100 in Cost-Sharing (including before the Deductible) for a 30-day supply for an insulin drug.	20% Coinsurance after Deductible	See benefit for description Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under Durable Medical Equipment and Braces.

Additional Services, Equipment and Devices	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
• Diabetic Education **Preauthorization Required**	Depending upon where the Covered Service is provided, Benefits for diabetic education will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, Benefits for diabetic education will be the same as those stated under each Covered Service category in this Schedule of Benefits.	20% Coinsurance after Deductible	
Durable Medical Equipment and Braces				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Enteral Nutrition				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids				
• Prescription Hearing Aids	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.
• Over-the-	Covered in full not	Covered in full not	Non-Participating	

Additional Services, Equipment and Devices	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Counter Hearing Aids	subject to Deductible	subject to Deductible	Provider benefits are not available for over-the-counter hearing aids.	
Cochlear Implants				
	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Post-cochlear implant aural therapy is limited to 30 visits per plan year.
Gender Dysphoria				
Preauthorization Required	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and Outpatient Prescription Drugs	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and Outpatient Prescription Drugs	Depending upon where the Covered Service is provided, Benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits and Outpatient Prescription Drugs	See benefit for description Limits for voice modification therapy and/or voice lessons will be the same as, and combined with outpatient speech therapy limits as described under Habilitation Services and Rehabilitation Services.
Hospice Care				
• Inpatient	Benefits will be the same as those stated under Inpatient Hospital in this Schedule of Benefits.	Benefits will be the same as those stated under Inpatient Hospital in this Schedule of Benefits.	20% Coinsurance after Deductible	See benefit for description Five (5) visits for family bereavement counseling

Additional Services, Equipment and Devices	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Outpatient **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
Medical Supplies				
Preauthorization Required	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	See benefit for description
Orthoptic Exercises and Corneal Topographic Procedures				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description **Orthoptic Exercises** Limited to one diagnostic visit and two therapeutic/follow-up visits per year.
Prosthetic Devices				
• External	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Benefits are limited to a single purchase

Additional Services, Equipment and Devices	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
				of each type of prosthetic device per limb per lifetime with Coverage for repairs and replacements. Wigs are limited to one wig per lifetime. Once this limit is reached, benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.
• Internal **Preauthorization Required**	Covered in full. Surgery is subject to either the Outpatient Hospital Surgery Facility Cost-Share or the Inpatient Hospital Cost-Share.	Covered in full. Surgery is subject to either the Outpatient Hospital Surgery Facility Cost-Share or the Inpatient Hospital Cost-Share.	20% Coinsurance after Deductible	

Inpatient Services and Facilities	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking Services				
Preauthorization Required	Covered in full not subject to Deductible	$60 Copayment per service not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)				
Preauthorization Required. However Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Observation Stay				
	$150 Copayment per visit not subject to Deductible	$150 Copayment per visit not subject to Deductible	$150 Copayment per visit not subject to Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)				

Inpatient Services and Facilities	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Preauthorization Required	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	undefined% Coinsurance after Deductible	See benefit for description Limited to: • 30 days per year in a Skilled Nursing Facility. • Covered Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)				
Preauthorization Required	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	20% Coinsurance after Deductible	See benefit for description Limited per year to 60 days for any combination of physical therapy, occupational therapy and speech therapy.
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)				
Preauthorization Required	$500 Copayment per Inpatient Stay	$500 Copayment per Inpatient Stay	20% Coinsurance	See benefit for description

Inpatient Services and Facilities	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
	not subject to Deductible	not subject to Deductible	after Deductible	Limited per year to 60 days for any combination of physical therapy, occupational therapy and speech therapy.
Centers of Excellence				
We Cover the following Services only when performed at Centers of Excellence: • Transplants. **Preauthorization Required**	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Depending upon where the Covered Service is provided, benefits will be the same as those stated under each Covered Service category in this Schedule of Benefits.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Mental Health and Substance Use Disorder Services	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)				
Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)				
• Office Visits	$25 Copayment per visit not subject to Deductible	$25 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• Intensive Behavioral Therapy **Preauthorization Required**	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
ABA Treatment for Autism Spectrum Disorder				
Preauthorization Required	$25 Copayment	$25 Copayment	20%	See benefit

Mental Health and Substance Use Disorder Services	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
	per visit not subject to Deductible	per visit not subject to Deductible	Coinsurance after Deductible	for description
Assistive Communication Devices for Autism Spectrum Disorder				
Preauthorization Required	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)				
Preauthorization Required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	$500 Copayment per Inpatient Stay not subject to Deductible	$500 Copayment per Inpatient Stay not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				
• Office Visits	$25 Copayment per visit not subject to Deductible	$25 Copayment per visit not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Opioid Treatment Programs	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	
• All Other Outpatient	Covered in full not	Covered in full not	20%	

Mental Health and Substance Use Disorder Services	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment	subject to Deductible	subject to Deductible	Coinsurance after Deductible	
• Intensive Behavioral Therapy	Covered in full not subject to Deductible	Covered in full not subject to Deductible	20% Coinsurance after Deductible	

Outpatient Prescription Drugs Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and are obtained at a Participating Pharmacy.	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy (30-day supply)				
You are not responsible for paying a Cost-Share for PPACA Zero Cost Share Preventive Care Medications. Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. You are not responsible for paying a Copayment and/or Coinsurance for Prescription Drugs on the list of zero cost-sharing medications.	**Tier 1** $15 Copayment per Prescription Order or Refill not subject to Deductible. **Tier 2** $30 Copayment per Prescription Order or Refill after Prescription Drug Deductible. **Tier 3** $60 Copayment per Prescription Order or Refill after Prescription Drug Deductible. The Deductible does not apply to certain Prescription Drugs. Visit Our website at www.myuhc.com to review Our Prescription Drug List or call the number on Your ID card to learn more.	**Tier 1** $15 Copayment per Prescription Order or Refill not subject to Deductible. **Tier 2** $30 Copayment per Prescription Order or Refill after Prescription Drug Deductible. **Tier 3** $60 Copayment per Prescription Order or Refill after Prescription Drug Deductible. The Deductible does not apply to certain Prescription Drugs. Visit Our website at www.myuhc.com to review Our Prescription Drug List or call the number on Your ID card to learn more.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Mail Order Pharmacy	You are not responsible for paying a Cost-Share for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Copayment and/or Coinsurance for Prescription Drugs on the list of zero cost-sharing medications.			

Outpatient Prescription Drugs Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and are obtained at a Participating Pharmacy.	**Preferred Provider** **Member Responsibility for Cost-Sharing** **(Preferred Provider level of benefits may not apply to all categories)**	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	**Limits**
	You may be required to fill the first Prescription Drug order and obtain 2 refills through a retail pharmacy before using a mail order Participating Pharmacy. To maximize Your benefit, ask Your Physician to write Your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Cost-Share 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. Be sure Your Physician writes Your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.			
• **Up to a 90-day supply**	**Tier 1** $37.50 per Prescription Order or Refill not subject to Deductible. **Tier 2** $75 per Prescription Order or Refill after Prescription Drug Deductible. **Tier 3** $180 per Prescription Order or Refill after Prescription Drug Deductible.	**Tier 1** $37.50 per Prescription Order or Refill not subject to Deductible. **Tier 2** $75 per Prescription Order or Refill after Prescription Drug Deductible. **Tier 3** $180 per Prescription Order or Refill after Prescription Drug Deductible.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Additional Benefits Covered by Rider	Preferred Provider Member Responsibility for Cost-Sharing (Preferred Provider level of benefits may not apply to all categories)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture				
	$40 Copayment per visit not subject to Deductible	$40 Copayment per visit not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost.	See benefit for description

Outpatient Prescription Drug Rider

Oxford Health Insurance, Inc.

This Rider to the Group Policy is issued to the Group and provides benefits for Prescription Drugs.

Because this Rider is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in either the Certificate of Coverage (Certificate) in Section I: Definitions or in this Rider in Section 6: Definitions.

When we use the words "We," "Us," and "Our" in this document, We are referring to Oxford Health Insurance, Inc. When We use the words "You" and "Your" We are referring to people who are Members, as the term is defined in the Certificate in Section I: Definitions.

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.

NOTE: The Coordination of Benefits provision in the Certificate in Section XVIII: Coordination of Benefits applies to Prescription Drugs covered through this Rider. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as benefits for Covered Services described in the Certificate.

Oxford Health Insurance, Inc.

Junior Harewood

President

Section 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; 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.
- Certain vaccines/immunizations administered at a Participating Pharmacy.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, including in vitro fertilization and Preimplantation Genetic Testing (PGT), in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid

Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid overdose reversal medication, including when dispensed over-the-counter.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider. You may request an exception by having Your attending Health Care Provider complete the Contraception Exception Form and sending it to Us. Visit Our website at www.myuhc.com or call the number on Your ID card get a copy of the form or to find out more about this exception process.

Refills

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

Section 2 - Benefit and Payment Information

Cost-Sharing Expenses

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

You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

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

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

Coupons and Other Financial Assistance

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

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and 3) all Generic Drugs.

Participating Pharmacies

For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

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

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

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

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.

Designated Pharmacies

If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs. However, We will provide benefits that apply to Prescription Drugs dispensed by a Designated Pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as the Designated Pharmacy.

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

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

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

- Age related macular edema;
- Allergies;
- Anemia, neutropenia, thrombocytopenia;
- Anticonvulsant;
- Antihyperlipidemic;
- Anti-infective;
- Cardiovascular;
- CNS Agents;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hematologic;
- Hemophilia;
- Hepatitis B, hepatitis C;
- Hereditary angioedema;
- Immune deficiency;
- Immune modulator;
- Infertility;

- Inflammatory Conditions;
- Iron overload;
- Iron toxicity;
- Liver Disease;
- Lupus;
- Multiple sclerosis;
- Muscular dystrophy;
- Oncology;
- Ophthalmic;
- Orphan medications;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Pulmonary arterial hypertension;
- Respiratory condition (e.g., asthma);
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis);
- Sickle Cell Disease;
- Spinal muscular atrophy;
- Transplant;
- RSV prevention;
- Ulcerative colitis.

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, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply. You are responsible for paying the lower of:

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

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

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills).

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

- Attention-deficit/hyperactivity disorder (ADHD);
- Agents used for dry mouth;
- Alzheimer’s disease;
- Asthma;

- Blood pressure;
- Chest pain;
- Constipation;
- Contraceptives;
- Depression;
- Diabetes;
- Diabetic supplies;
- Diarrhea;
- Elevated thyroid hormone;
- Fibromyalgia;
- Glaucoma;
- Gout;
- Heart failure;
- Heart rhythm;
- High cholesterol;
- Hormone replacement;
- Inflammatory bowel disease;
- Irritable bowel disease;
- Myasthenia gravis;
- Neuropathic pain;
- Osteoporosis;
- Overactive bladder;
- Pancreatic enzyme replacement;
- Parkinson’s disease;
- Phosphate binding agents;
- Potassium replacement;
- Rheumatoid arthritis;
- Seizures;
- Stroke and heart attack prevention;
- Testosterone replacement;
- Thyroid hormone replacement;
- Ulcers, heartburn and reflux;
- Vitamins;
- Women’s health.

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.myuhc.com or by calling the number on Your ID card. The

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

Mail Order

Certain Prescription Drugs may be ordered through Our mail order pharmacy, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply. You are responsible for paying the lower of:

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

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

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

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

We will provide benefits that apply to Prescription Drugs dispensed by a mail order pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as a participating mail order pharmacy.

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

Prescription Drug List Changes

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

Tier Status

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

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

Supply Limits

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

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

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

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

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.myuhc.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.

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.

Emergency Refill During a State Disaster Emergency

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

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.

Half Tablet Program

Certain Prescription Drugs may be designated as eligible for Our voluntary half tablet program. This program provides the opportunity to reduce Your Prescription Drug out-of-pocket expenses by up to 50% by using higher strength tablets and splitting them in half. If You are taking an eligible Prescription Drug, and You would like to participate in this program, please call Your Physician to see if the half tablet program is appropriate for Your condition. If Your Physician agrees, he or she must write a new prescription for Your medication to enable Your participation.

You can determine whether a Prescription Drug is eligible for the voluntary half tablet program by accessing Our website at www.myuhc.com or by calling the number on Your ID card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes. 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 up to a 15-day supply of Your Prescription Order for certain drugs filled at a Designated Pharmacy instead of the full Prescription Order. You initially pay half the 30-day Cost-Sharing. The therapeutic classes of Prescription Drugs that are included in this program are: Oncology.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Participating Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the mail order Participating Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Section 3 - Medical Management

This Rider 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.

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. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.myuhc.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market. However, We will not add Preauthorization requirements to a Prescription Drug on Our Prescription Drug List during a Plan Year unless the requirements are added pursuant to FDA safety concerns. Your Provider may check with Us to find out which Prescription Drugs are Covered.

Step Therapy

Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate. We will not add step therapy requirements to a Prescription Drug on Our Prescription Drug List during a Plan Year unless the requirements are added pursuant to FDA safety concerns

Coupons, Incentives and Other Communications

We may send mailings or provide other communications to You, your Physician, or Your pharmacy about offers that enable You, as you determine, to purchase a Prescription or non-Prescription Drug at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only You and Your Physician can determine whether a change in Your Prescription and/or non-Prescription Drug regimen is appropriate for Your medical condition.

Medication Adherence/Compliance Programs

Certain programs may allow You to receive an enhanced Benefit based on Your actions. Such actions may include adherence/compliance to medication or treatment regimens, and/or taking part in health management programs such as educational sessions.

For example, the Refill and Save program may allow You to receive a discount on Your Copayment or Coinsurance for certain Prescription Drugs when you Refill at the retail pharmacy within a defined period of time in accordance with Your Prescription Order. If You Refill Your Prescription Drug for a qualifying medication, You can save $20 on the usual Copayment or Coinsurance. If You Refill Your Prescription Drug through a mail order pharmacy, You can save $50 on Your Copayment or Coinsurance based on a

90-day supply. You do not have to sign up or complete a rebate form, You just Refill and save. To qualify for the savings, You must Refill Your Prescription Drug within 30 days of the day the Prescription Drug was scheduled to run out. So if the prescription is written for 30 days, You have an additional 30-day grace period (for a total of 60 days) to Refill the Prescription Drug.

We will provide communications to You when these programs become available. You may also access information on these programs by contacting Us at Our website at www.myuhc.com or the telephone number on Your ID card and either requesting a copy of the information on these programs be mailed to You or by having Our representative look up the particular program and explain the benefit to You.

Section 4 - Limitations/Terms of Coverage

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date, We notify You, We will select a single Participating Pharmacy for You.
3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $50 require Your Provider to obtain Preauthorization.
4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of 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.
5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.
7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, 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 Prescription Drug List. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.
8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

Section 5 - General Conditions

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.

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. 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. If a Prescription Drug is eligible for a rebate, most of the projected value of the rebate will be used to reduce the Allowed Amount for the Prescription Drug. Your Deductible or Coinsurance is calculated using that reduced Allowed Amount. The remaining value of that rebate will be used to reduce costs for all Members enrolled in coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than Our estimate.

Section 6 - Definitions

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

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.
2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.
3. **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.
4. **List of Preventive Medications** - A list that identifies certain Prescription Drugs on the Prescription Drug List that are intended to reduce the likelihood of sickness. You may find the List of Preventive Medications by contacting us at our website at www.myuhc.com or the telephone number on your ID card.
5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.
6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.
8. **PPACA** - Patient Protection and Affordable Care Act of 2010.
9. **PPACA Zero Cost Share Preventive Care Medications** - The medications that are obtained at a Participating Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Cost-Sharing as required by applicable law under any of the following:
   - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
   - Certain immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
   - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

   You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at Our website at www.myuhc.com or the telephone number on your ID card.

10. **Preferred 90 Day Retail Participating Pharmacy** - A retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

11. **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. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

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

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

14. **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.

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

Reimbursement for Travel and Lodging Expenses Rider

Oxford Health Insurance, Inc.

A. **General.**

This rider amends the benefits of Your Certificate as follows:

1. **Travel and Lodging Expenses**

- We will reimburse certain travel and lodging expenses for You to travel at least 50 miles from Your residence to another State to access Covered Services when access to Covered Services is not available to You due to a law or regulation in the State where You reside unless such reimbursement is prohibited by law. We will reimburse You up to $2,000 per Plan Year for Your travel and lodging expenses. Lodging expenses are limited to $50 per night for You, or $100 per night if You are traveling with a companion.
- To get reimbursed by Us, You must submit Your travel and lodging receipts to Us. For more information, call the number on Your ID card or visit Our website at www.myuhc.com.

2. **Access to Covered Services**

- If You are traveling to another State to access Covered Services from a Participating Provider, You will be responsible for Your In-Network Cost-Sharing for the Covered Services.
- If You are traveling to another State to access Covered Services from a Non-Participating Provider, You must contact Us at the number on Your ID card for an authorization before receiving services. If an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as out-of-network and You will be responsible for Your Out-of-Network Cost-Sharing and the difference between the Provider's charge and Our Allowed Amount.

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.

Junior Harewood

President

Domestic Partner Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides coverage for Domestic Partners.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section I: Definitions* and in this Rider below.

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Members, as the term is defined in the *Certificate* in *Section I: Definitions*.

Coverage for Domestic Partners

This rider covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under the *Certificate* also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
    a) An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to contract;
        - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application; and
        - Neither individual has been registered as a member of another domestic partnership within the last six months;
    b) Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
    c) Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account;
        - A joint credit card or charge card;
        - Joint obligation on a loan;
        - Status as an authorized signatory on the partner's bank account, credit card or charge card;
        - Joint ownership of holdings or investments;
        - Joint ownership of residence;
        - Joint ownership of real estate other than residence;
        - Listing of both partners as tenants on the lease of the shared residence;
        - Shared rental payments of residence (need not be shared 50/50);

- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Junior Harewood, President

Acupuncture Services Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides benefits for acupuncture services

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate) in Section I: Definitions.*

When we use the words "we", "us", and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Members, as the term is defined in the *Certificate* in *Section I: Definitions.*

The following provision is added to the *Certificate, Section IX: Outpatient and Professional Services:*

Acupuncture Services

Benefits are provided for acupuncture services that are performed in an office setting by a provider who is:

- Practicing within the scope of his or her license; or
- Certified by a national accrediting body;
- One of the following:
  - A licensed acupuncturist (LAC);
  - A licensed naturopath;
  - A Physician (Doctor of Medicine or Doctor of Osteopathy) who has been credentialed as a Physician acupuncturist.

Benefits include acupuncture services for the treatment of the following conditions:

- Chronic pain.
- Post-operative nausea.
- Nausea as a result of chemotherapy.
- Nausea during early Pregnancy.

Benefits do not include:

- Treatment provided outside of the state in which the provider is licensed to practice.
- Acupuncture services provided by Non-Participating Providers even if your plan includes Out-of-Network Benefits.
- Acupuncture services for the treatment of weight loss.

Please refer to the Schedule of Benefits which attached to your Certificate for Cost-Sharing and visit limit information.

Junior Harewood

President

Patient Protection and Affordable Care Act (PPACA) Zero Cost Share Preventive Care Medications Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides benefits for PPACA Zero Cost Preventive Care Medications.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section I: Definitions* and in this Rider below.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your," we are referring to people who are Members, as the term is defined in the *Certificate* in *Section I: Definitions.*

Benefits for PPACA Zero Cost Share Preventive Care Medications

Benefits are provided for PPACA Zero Cost Share Preventive Care Medications that are obtained at a Participating Pharmacy with a Prescription Order or Refill from a Physician. Benefits are payable at 100% of the Prescription Drug Cost (without application of any Cost-Sharing). You may determine whether a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Except as specifically described in this Rider, benefits under the Policy are not available for prescription drug products for outpatient use.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your PPACA Zero Cost Share Preventive Care Medication at a Participating Pharmacy or you must provide the Participating Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Participating Pharmacy, you must pay the UCR for the PPACA Zero Cost Share Preventive Care Medication at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section XIV: Claim Determinations.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the PPACA Zero Cost Share Preventive Care Medication was dispensed.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain PPACA Zero Cost Share Preventive Care Medications, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those PPACA Zero Cost Share Preventive Care Medications.

If you are directed to a Designated Pharmacy and you choose not to obtain your PPACA Zero Cost Share Preventive Care Medication from a Designated Pharmacy, no benefit will be paid for that PPACA Zero Cost Share Preventive Care Medication.

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. 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 may change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage. If a Prescription Drug is eligible for a rebate, most of the rebate will be used to reduce the Allowed Amount for the Prescription Drug. Your Deductible or Coinsurance is calculated using that reduced Allowed Amount. The remaining value of that rebate will be used to reduce costs for all Members enrolled in coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than Our estimate.

How Do Supply Limits Apply?

Some PPACA Zero Cost Share Preventive Care Medications are subject to supply 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 may determine whether a PPACA Zero Cost Share Preventive Care Medication has been assigned a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card or upon your request to receive a copy of the current listing.

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, 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 a subsequent 12 month dispensing of the same contraceptive drug or device, You are responsible for up to twelve (12) cost-sharing amounts.

Defined Terms

Designated Pharmacy - a pharmacy that has entered into an agreement with us, or with an organization contracting on our behalf, to provide specific PPACA Zero Cost Share Preventive Care Medications. Not all Participating Pharmacies are Designated Pharmacies.

Participating Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Preventive Care Medications to Members.

- Agreed to accept specified reimbursement rates for dispensing Preventive Care Medications.
- Been designated by us as a Participating Pharmacy.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Participating Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Cost (without application of any Cost-Sharing) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Cost - the rate we have agreed to pay our Participating Pharmacies for a PPACA Zero Cost Share Preventive Care Medication dispensed at a Participating Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Order or Refill - the directive to dispense a Preventive Care Medication issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

UCR (Usual, Customary and Reasonable) - the usual fee that a pharmacy charges individuals for a Preventive Care Medication without reference to reimbursement to the pharmacy by third parties. This fee includes a dispensing fee and any applicable sales tax.

Junior Harewood

President

Quit for Life Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides benefits for Quit for Life.

Because this Rider is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section I: Definitions.*

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to people who are Members, as the term is defined in the *Certificate* in *Section I: Definitions.*

Junior Harewood

President

Quit for Life

Purpose

The purpose of this program is to encourage you to overcome tobacco addiction.

Description

We provide benefits in connection with your use of a tobacco cessation program. The tobacco cessation program is known as our Quit for Life Program and will provide you with coaching support for your individual tobacco cessation plan.

Eligibility

You, the Subscriber, and the Subscriber's covered Spouse can participate in the tobacco cessation program.

Participation

Participants can enroll at www.myuhc.com. Upon enrollment, participants will have access to the following:

- **Online Support.** Access to a member portal with an action plan and quit guide.
- **Mobile App.** 24/7 urge management support and access to your individual program.
- **Live Tobacco Free Course.** Online quit tobacco course allows you to participate at your own pace as part of your individual program.
- **Support from a Quit Coach.** Access to a coach who will help you create a personalized action plan to quit and stay on track.
- **Text support.** Provides daily tips, encouragement and reminders.

Junior Harewood

President

Real Appeal Rider

Oxford Health Insurance, Inc.

This Rider to the Policy provides benefits for virtual obesity counseling services for eligible Members through Real Appeal. There is no Cost-Sharing (Copayments, Deductibles or Coinsurance) You must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Members 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session. You may attend up to 32 coaching sessions.

These Covered Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If You would like information regarding these Covered Services, You may contact Us through www.realappeal.com, https://member.realappeal.com or at the number shown on Your ID card.

Junior Harewood

President

Kidney Donor Travel and Lodging Program Rider

Oxford Health Insurance, Inc.

This Rider to the Policy provides a donor travel and lodging allowance related to living kidney transplantation.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section I: Definitions.*

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc.

Kidney Donor Travel and Lodging Program

The *Kidney Donor Travel and Lodging Program* provides support for living kidney donors when the intended recipient of the kidney is a Member under the Policy. The program provides an allowance for travel and lodging expenses for an approved living kidney donor and travel companion. The living kidney donor is not required to be a Member under the Policy.

Donors must be approved by us for participation in this program. This program provides an allowance for incurred travel and lodging expenses only and is independent of any existing medical coverage available for the donor or Covered Person. Once approved, an allowance of up to $6,000 per donor will be provided for travel and lodging expenses incurred as a part of the entire kidney donation process, based on the *U.S. General Services Administration* travel rates. Expenses incurred will include travel and lodging expenses for the donor's first evaluation through follow-up evaluation(s) up to two years after donor surgery.

If you would like additional information regarding the *Kidney Donor Travel and Lodging Program*, you may contact us at www.myuhc.com.

Junior Harewood

President

Sweat Equity Fitness Reimbursement Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the Sweat Equity Fitness Reimbursement program.

Because this Rider is part of a legal document (the Group Policy), We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section I: Definitions*.

When We use the words "We", "Us", and "Our" in this document, We are referring to Oxford Health Insurance, Inc. When We use the words "You" and "Your" We are referring to the Subscriber and Covered Dependent Members age thirteen (13) and older.

Sweat Equity Fitness Reimbursement Program

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

We will provide partial reimbursement for eligible fees associated with certain exercise that promotes cardiovascular wellness as described below.

Exercise activity fees include costs You pay for exercise facility fees, or exercise facility and class membership fees, outdoor bike rentals, organized group in-person exercise classes, individual fitness in-person instruction, organized group in-person physical event, such as a marathon but only if such fees are paid to facilities or organizations which maintain equipment and/or offer programs that promote cardiovascular wellness and are available to the general public.

Membership in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits, organized group exercise classes, sessions, bike rides or organized group physical events. We will not provide reimbursement for the purchase of equipment, clothing, vitamins or other items or services that may be offered by the facility or organization (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:

- Be an active member of the facility or program or attend organized group classes at the exercise facility or organization, and
- Complete a combined total of 50 visits, organized group classes, sessions, bike rides or organized group physical events in a six-month period.

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

- A completed reimbursement form from the facility or program of Your visits, sessions, and events. Each time You use the exercise facility, a facility representative must sign and date the reimbursement form. You can obtain the reimbursement form on Our website at www.myuhc.com or by calling the number shown on Your ID card.
- A copy of Your current facility bill(s), class or program bill which shows the fee paid for Your class membership, workout visits, organized group classes, sessions, bike rides or organized group physical events.
- A copy of the brochure or website printout that outlines the services or programs the exercise facility, class, session or event offers.

Once We receive the completed reimbursement form; documentation of the visits and the facility, class, event, or program bill(s), the Subscriber will be reimbursed up to $200 and each Covered Dependent Member age thirteen (13) years of age or older will be reimbursed up to $100 or the actual cost of the

eligible facility, class, program, session, event or membership per six month period, whichever is less. If You are unable to meet a standard related to a health factor for reimbursement under this fitness reimbursement program, You might qualify for an opportunity to earn the same reward by different means. Call Us at the number on Your identification (ID) card, and We will work with You and, if necessary, Your Physician, to find another way for You to earn the same reward.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable. We encourage You to make the most of your reward by using it for goods or services that promote good health.

Reimbursement must be requested within 120 days of the end of the six-month period. Reimbursement will be issued only after You have completed each six-month period even if 50 visits are completed sooner.

Junior Harewood

President

New York Out-of-Network Benefits Disclosure

Your plan has out-of-network benefits. This means that you may choose to receive covered services from non-participating (out-of-network) providers1. Some services are only covered when you go to a participating (network) provider. The Out-of-Network Benefits Rider and Schedule of Benefits in your plan documents provide more information. Please make sure to review your Schedule of Benefits for a list of the services covered out-of-network.

How does my plan reimburse claims?

Your plan reimburses claims using an Allowed Amount. The Allowed Amount is the maximum amount allowed for a covered service. Under your plan, the Allowed Amount for out-of-network benefits is based on Medicare and other sources, when Medicare data is not available. You are responsible to pay your share of the Allowed Amount and any difference between the Allowed Amount and the out-of-network provider's billed charge.

How does the Allowed Amount compare to the usual cost for out-of-network services?

The amount can vary depending on the service. Below are ranges showing the average Allowed Amounts compared to the usual cost. For purposes of this disclosure, the usual cost is based on the FAIR Health rate at the 80th percentile. This FAIR Health rate is also referred to as UCR in New York. The Allowed Amount for a specific service may be higher or lower than the range.

The Allowed Amount for:

- Non-participating facilities and ambulatory service centers typically ranges from 55% - 146% of UCR.
- Other non-participating providers typically ranges from 14% - 207% of UCR. This amount can vary significantly depending on the service provided. For example, within this range the Allowed Amount for:
  - Non-participating office visits typically ranges from 14% - 177% of UCR.
  - Non-participating surgical services typically ranges from 6% - 164% of UCR.

These averages can vary significantly at the claim level depending on the procedure(s) and the FAIR Health rate for a specific service and are not a guarantee of payment. Individual member experience may be different from these averages.

The ranges are intended to give you a general idea of the Allowed Amount. If the service requires prior authorization and we know that you are using an out-of-network provider, an estimate of the Allowed Amount will be included in an approval letter. You may also estimate the anticipated out-of-pocket cost for out-of-network services by:

- Contacting your provider for the amount that he/she will charge.
- services in your geographic area or ZIP code and applying these percentages to estimate the Allowed Amount. More information and a link to the FAIR Health website are available on our website at **www.uhc.com/legal/required-state-notices/new-york/fairhealth-notice**.
- Reviewing a prior authorization approval letter. If a service requires prior authorization and we know that you are using an out-of-network provider, an estimate of the Allowed Amount will be included in the approval letter.
- Calling Customer Service using the phone number on your ID card for an estimate of your financial responsibility when a procedure has been scheduled. Your doctor's office can give you the procedure codes that will help us provide an estimate of the Allowed Amount.

Will the Allowed Amount be the final reimbursement amount for the out-of-network claim?

The final out-of-network reimbursement amount could be lower than the Allowed Amount quoted. The Allowed Amount reflects the maximum amount applied to each service or procedure.

Your plan applies nationally recognized payment rules to claims that may change the final reimbursement amount. We may not know which payment rules will apply until we get a claim from the provider that shows us the services and procedures you received.

Examples of these payment rules include:

- If a single code describes the procedure and your provider bills several procedure codes, we will apply one inclusive Allowed Amount rather than a separate Allowed Amount for each billed code.
- If a surgery involves several procedures, coverage for some or all of the procedures may be made through a single Allowed Amount for the primary procedure. Some secondary procedures may be eligible for reimbursement at 50% of the Allowed Amount.
- If you receive services from a health care professional who is not a physician, such as a physician's assistant, the Allowed Amount will be less than the Allowed Amount for a physician.

You also have a cost-share obligation for out-of-network claims. This typically consists of a deductible and coinsurance, and in some instances, may include a copay. Your plan has a maximum cost-share amount. This is called an out-of-pocket limit. Once the out-of-pocket limit is reached, the out-of-network cost-share no longer applies to claims. These amounts can be found in your plan documents.

You are also responsible for the amount, if any, by which the non-participating provider's billed charge exceeds the Allowed Amount. This excess amount does not apply to your cost-share and out-of-pocket limit.

Remember, we recommend using a network provider so you can get the care you need at network costs.

Oxford Insurance products are underwritten by Oxford Health Insurance, Inc.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card Monday through Friday, 8 a.m. to 6 p.m. ET. TTY users can dial 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務. 請撥打會員卡所列的免付費會員電話號碼.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

Wellness Program Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the wellness program. The purpose of this wellness program is to encourage you to take a more active role in managing your health and well-being.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section I: Definitions*.

When we use the words "we," "us," and "our" in this document, we are referring to Oxford Health Insurance, Inc. When we use the words "you" and "your" we are referring to the Subscriber or their Covered Spouse.

Wellness and Additional Onsite Preventive Programs

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

- A designated health or fitness incentive program
- Designated healthy activities

The group will select options in advance of effective date and determine eligibility and whether the program is available to subscriber only or covered spouses/ dependents.

Subscribers can participate in the wellness program.

The wellness program is available online and the preferred method for accessing it is through www.myuhc.com. You need to have access to a computer with internet access in order to participate in the website program. However, if You do not have access to a computer, please call us at the phone number on Your ID card and we will provide You with information regarding how to participate without internet access.

Rewards for participation in a wellness program include:

- Monetary rewards in the form of gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.

Junior Harewood

President

UnitedHealthcare Rewards Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards program.

Because this Rider is part of a legal document (the Group Policy), We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in the Certificate of Coverage in Section I: Definitions.

When We use the words "We," "Us," and "Our" in this document, We are referring to Oxford Health Insurance, Inc. When We use the words "You" and "Your" We are referring to the Subscriber or their Covered Dependent Spouse.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards You for completing certain criteria, as described below. You may choose to complete any, or all, of the below criteria to earn a reward.

If You are unable to meet a standard related to a health factor for a reward under the program, then You might qualify for an opportunity to earn the same reward by different means. You can call Us at the telephone number listed on Your ID card, and We will work with You (and, if necessary, with Your Physician) to find another way for You to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in Your Health Savings Account (HSA).
- A device credit.
- A prepaid Visa® gift card.
- Retailer gift card.
- Another type of incentive (such as a prepaid Visa® debit card) to help encourage You to participate in the program, administered as determined by Us.

Activity Targets

You may also receive a reward when You meet one or more of the activity targets listed below, based on the device You choose to track activity.

Activity Marker	**Activity Target**	**Reward**
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 steps per day	You can earn up to $300 in rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Actions and/or Activities	One or more actions and/or activities defined by Us and aimed at the following: • Health education;	

	• Improving health; or • Maintaining health	

You may access Your actions and/or activity tracking and rewards on the mobile application or www.myuhc.com.

If You have not achieved any of the above daily activity targets, You may be eligible to earn a reward for synchronizing or otherwise providing Your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable. We encourage You to make the most of Your reward by using it for goods or services that promote good health.

Rewards

Rewards listed above, when earned, will be credited to a Health Savings Account (HSA) or distributed in other reward types (such as a prepaid Visa® debit card) as applicable, administered by Us. It is Your responsibility to monitor all contributions made from all sources to Your Health Savings Account (HSA) to ensure that such contributions do not exceed the maximum allowed amount, if applicable. If reward amounts will exceed, or may potentially exceed, the maximum allowed amount for Your Health Savings Account (HSA), please contact Us to arrange for an alternative reward method.

Device

A device, which includes an application, approved by Us is used to track actions and/or activities towards earning a reward. If You choose to use a non-compatible device, You may be eligible to earn a reward; however, the reward may be limited.

Junior Harewood, President

President

Self Care Rider

This Rider to the Policy describes a self-help tool available to eligible Members.

Because this Rider is part of a legal document (the Group Policy), We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section I: Definitions*.

Self Care provides digital support techniques designed to help You relax, shift perspectives or cope with stressful situations.

Self Care provides tools and support, such as:

- Mood and health data tracking over time.
- Integrated goal-setting and progress assessments.
- Relaxation techniques.

Self Care can be accessed through the following links: www.myuhc.com or liveandworkwell.com, or by downloading the Self Care application on Your mobile device or you may call Us at the number on Your ID card to request that materials (toolkits, online resources, etc.) that are available via hardcopy be emailed or mailed to Your home.

Junior Harewood

President

One Pass Select Rider

Oxford Health Insurance, Inc.

This Rider to the Policy is issued to the Group and provides a description of the One Pass Select program.

Because this Rider is part of a legal document (the Group Policy), We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section I: Definitions*.

When We use the words "We," "Us," and "Our" in this document, We are referring to Oxford Health Insurance, Inc. When We use the words "You" and "Your" We are referring to Members age 18 and older.

One Pass Select

One Pass Select provides a discounted fitness membership that is available for purchase. One Pass Select allows You to select a network of fitness facilities based on price, fitness-facility type, and location preferences. The four tiers listed below offer You the ability to utilize multiple locations at no additional cost per month.

Membership choices include:

Membership Tiers	**Costs**	**Descriptions**
Classic	$29/month	10,000 fitness facilities.
Standard	$64/month	12,000 fitness facilities.
Premium	$99/month	14,000 fitness facilities.
Elite	$144/month	15,000 fitness facilities.

You may access the One Pass Select program through www.myuhc.com or Our mobile UnitedHealthcare app.

The One Pass program is offered by Optum. Payments made for the participation in the One Pass program will be made to Optum.

Junior Harewood

President

Federal Notices

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could

cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024:

We[1] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors**, if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**; however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders**, we may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

We will follow the more protective and stringent law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for

your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[1]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health

Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited: OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Language Assistance Services

We[3] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[3] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[3]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 1 of the Notice of Privacy Practices and Footnote 2 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

UnitedHealthcare Oxford

Out-of-Network Reimbursement Examples For Large Group Coverage

This summary gives examples of typical costs for out-of-network services under our three most commonly sold health insurance plans in New York county that includes zip code 11215. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document at www.oxfordhealth.com or by calling the toll-free member number on your health plan ID card.

Colonoscopy (Biopsy of Large Bowel Using an Endoscope) CPT Code: 45380 Anesthesia CPT Code: 00810 Pathology CPT Code: 88305					Laminotomy (Partial Removal of Bone with Release of Spinal Cord or Spinal Nerves of 1 Interspace in Lower Spine) CPT Code: 63030 Anesthesia CPT Code: 00630					Breast Reconstruction (Insertion of Tissue Expander in Breast) CPT Code: 19357 Anesthesia CPT Code: 00402				
Sample care costs:					**Sample care costs:**					**Sample care costs:**				
	UCR	**HGH**	**140 % MC**	**350% of MC**		**UCR**	**HGH**	**140% MC**	**350% of MC**		**UCR**	**HGH**	**140% MC**	**350% of MC**
Hospital Services	$6,153	$7,276	$1,648	$4,119	Hospital Services	$20,838	$26,880	$9,815	$24,537	Hospital Services	$6,293	$28,678	$22,730	$56,824
Physician Services	$1,855	$1,855	$350	$874	Physician Services	$14,535	$14,535	$1,851	$4,627	Physician Services	$27,022	$27,022	$2,701	$6,752
Anesthesia	$3,389	$3,389	$302	$756	Anesthesia	$6,715	$6,715	$656	$1,639	Anesthesia	$7,096	$7,096	$716	$1,790
Pathology	$325	$325	$116	$291	**Total**	**$42,088**	**$48,131**	**$12,321**	**$30,803**	**Total**	**$40,411**	**$62,796**	**$26,147**	**$65,367**
Total	**$11,722**	**$12,845**	**$2,416**	**$6,039**										
Patient pays:					**Patient pays:**					**Patient pays:**				
Deductibles	$2,000	$1,000	$4,000		Deductibles	$2,000	$1,000	$4,000		Deductibles	$2,000	$1,000	$4,000	
Copays	$0	$0	$0		Copays	$0	$0	$0		Copays	$0	$0	$0	
Coinsurance	$3,000	$425	$612		Coinsurance	$3,000	$3,000	$6,500		Coinsurance	$3,000	$3,000	$6,500	
Difference between UCR and what the plan pays	($1,123)	$9,306	$5,682		Difference between UCR and what the plan pays	($6,042)	$29,767	$11,285		Difference between UCR and what the plan pays	($22,385)	$14,265	($24,955)	
Total	**$5,000**	**$10,731**	**$10,294**		**Total**	**$5,000**	**$33,767**	**$21,785**		**Total**	**$5,000**	**$18,265**	**$10,500**	
OOP Max	$5,000	$4,000	$10,500			$5,000	$4,000	$10,500			$5,000	$4,000	$10,500	

UCR (usual and customary cost) is the amount providers typically charge for a service. This chart uses UCR based on FAIR Health at the 80th percentile for zip code 11215. Your provider may bill more than UCR.

Patient pays represents sample cost-sharing. Your cost-sharing may vary.

HGH is an example showing the maximum amount the plan pays. In these examples, the HGH plan pays based on data from third party sources at the 80th percentile; the deductible is $2,000 and the coinsurance is 30%.

MC (Medicare-based Rate) is an example showing the maximum amount this plan pays. In these examples, the MC plan pays based either on 140% or 350% of the Medicare rate or another payment method as explained in the plan's Certificate of Coverage.