Your Oxford Coverage

for all seasons

UnitedHealthcare®
Oxford

New York EPO

11409

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford Member, you have access to a series of programs and resources to help you along your road to health:

- A robust network of hospitals and providers from a local health plan with over 20 years of experience. If your employer's plan offers out-of-area coverage, you also have in-network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.
- Our *Healthy Bonus*®[1] program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Members can save on services such as weight loss programs, fitness equipment and publications.
- Our web site, *www.oxfordhealth.com*, which allows you to conduct business (e.g., request an ID card, update or correct any personal information, etc.) and access health information at your convenience.
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On-Call*®
- *Healthy Mind Healthy Body*® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information.

The following information is enclosed: your new Summary of Benefits, Certificate of Coverage and other important plan information. If you have questions about your coverage, or want to learn more about Oxford's programs and resources, please log on to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

Wishing you the best of health,

Oxford Health Plans

[1] *Healthy Bonus* offers are not insured benefits and are in addition to, and separate from, your benefit coverage through Oxford Health Plans. These arrangements have been made for the benefit of Members, and do not represent an endorsement or guarantee on the part of Oxford. Offers may change from time to time and without notice and are applicable to the items referenced only. Offers are subject to the terms and conditions imposed by the vendor. Oxford Health Plans cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford; however, any failure to receive offers should be reported to Oxford Customer Service by calling the number on your Member ID card.

Important Information

Reconstructive Breast Surgery Law

Effective October 21, 1998, health insurance carriers of group and individual commercial policies that cover mastectomies are required to cover reconstructive surgery or related services following a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998.

The Act guarantees coverage to any Member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. The health insurance company that issues the policy is required to provide coverage (as determined in consultation with the attending physician and the patient) for:

Individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

a. all stages of reconstruction of the breast on which the mastectomy has been performed;
b. surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. prostheses; and
d. treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided in the same manner as other medical and surgical benefits provided under this plan.

If you would like more information about this benefit, please read the enclosed Certificate of Coverage.

National Medical Support Notices

The New York State Insurance Department has issued guidance as to how health insurance policyholders and health insurance companies/ health maintenance organizations need to respond when they receive a "National Medical Support Notice" issued by the New York State Division of Child Support Enforcement. These notices require that a non-custodial parent provide health insurance for a dependent child. In some cases the non-custodial parents may not have elected coverage for themselves and may need to be enrolled in order to provide the coverage required pursuant to the National Medical Support Notice.

Any party that fails to comply with the court order becomes responsible for any healthcare costs incurred as a result of the non-compliance. Even when the non-custodial parent refuses to sign a required enrollment form, the policyholder and the insurer must take necessary steps to enroll the child even if it means enrolling the non-custodial parent against his/her will.

Thank you for your assistance in helping us to process these enrollments in compliance with the Insurance Department's directive.

UnitedHealthcare Oxford

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Gold Plan
HealthPass Insurance Trust - February 1st

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Deductible		Non-Participating Provider services are not covered
Individual	$1,250	except as required for Emergency Care.
Family	$2,500	
Out-of-Pocket Limit		Non-Participating Provider services are not covered
Individual	$4,500	except as required for Emergency Care.
Family	$9,000	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing		Limits
Primary Care Office Visits (or Home Visits)	$25 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Medications Administered in Office	$25 Copayment not subject to Deductible		
Specialist Office Visits (or Home Visits)	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Medications Administered in Office	$40 Copayment not subject to Deductible		
Medications Administered in an Outpatient Facility *Preauthorization; Referral Required*	$200 Copayment after Deductible		
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Adult Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Mammography Screenings*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	

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Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Preventive Care			
Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider services are not covered and You pay the full cost	
Bone Density Testing*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider services are not covered and You pay the full cost	

Referral Required

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	Covered in full	See benefit for description
Non-Emergency Ambulance Services *Preauthorization; Referral Required*	Covered in full	Covered in full	See benefit for description
Emergency Department *Copayment/Coinsurance waived if Hospital admission.*	$400 Copayment not subject to Deductible	$400 Copayment not subject to Deductible	See benefit for description
Urgent Care Center *Referral Required*	$65 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a Freestanding Radiology Facility or Office Setting	$50 Copayment after Deductible		
Performed as Outpatient Hospital Services *Preauthorization; Referral Required*	$250 Copayment after Deductible		

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Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Allergy Testing & Treatment		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Specialist Office	$40 Copayment not subject to Deductible		
Preauthorization; Referral Required			
Ambulatory Surgical Center Facility Fee	$200 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Anesthesia Services (all settings)	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Autologous Blood Banking	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Cardiac & Pulmonary Rehabilitation		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a Specialist Office	$40 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services	$40 Copayment not subject to Deductible		
Performed as Inpatient Hospital Services	Included As Part of Inpatient Hospital Service Cost-Sharing		
Preauthorization; Referral Required			
Chemotherapy		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Specialist Office	$40 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services	$500 Copayment after Deductible		
Preauthorization; Referral Required			
Chiropractic Services	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Clinical Trials	Use Cost-Sharing for appropriate service	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diagnostic Testing		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Specialist Office	$40 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services	$35 Copayment not subject to Deductible		
Preauthorization; Referral Required			

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Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Dialysis		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Freestanding Center or Specialist Office Setting	$40 Copayment not subject to Deductible		Dialysis performed by Non-Participating Providers is limited to 10 visits per Calendar Year
Performed as Outpatient Hospital Services	$500 Copayment after Deductible		
Preauthorization; Referral Required			
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	60 visits per Calendar Year for PT/OT/ST combined
Preauthorization; Referral Required			
Home Health Care	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	40 visits per Calendar Year
Preauthorization; Referral Required			
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Infusion Therapy		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in Specialist Office	$40 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services	$500 Copayment after Deductible		
Home Infusion Therapy	$40 Copayment not subject to Deductible		Home infusion counts towards home health care Visit Limits
Preauthorization; Referral Required			
Inpatient Medical Visits	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preauthorization; Referral Required			
Laboratory Procedures		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Freestanding Laboratory Facility or Specialist Office	Covered in Full not subject to Deductible		
Performed as Outpatient Hospital Services	Covered in Full not subject to Deductible		
Preauthorization; Referral Required			
Maternity & Newborn Care		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prenatal Care	Covered in Full		
Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible		One (1) Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

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Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care			
Physician and Midwife Services for Delivery	20% Coinsurance after Deductible		
Breast Pump	Covered in Full		Covered for duration of breast feeding
Postnatal Care *Preauthorization Required for Inpatient Services; Breast Pump*	Covered in Full		
Outpatient Hospital Surgery Facility Charge *Preauthorization; Referral Required*	$500 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preadmission Testing *Preauthorization; Referral Required*	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a PCP Office	$25 Copayment not subject to Deductible		
Performed in a Freestanding Radiology Facility or Specialist Office	$35 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services *Preauthorization; Referral Required*	$35 Copayment not subject to Deductible		
Therapeutic Radiology Services		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Performed in a Freestanding Radiology Facility or Specialist Office	$40 Copayment not subject to Deductible		
Performed as Outpatient Hospital Services *Preauthorization; Referral Required*	$500 Copayment after Deductible		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *Preauthorization; Referral Required*	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	60 visits per Calendar Year for PT/OT/ST combined. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other *Preauthorization; Referral Required*	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Hospital Surgery	20% Coinsurance after Deductible		All Transplants must be performed at Designated Facilities
Outpatient Hospital Surgery	20% Coinsurance after Deductible		

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Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)			
Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible		
Office Surgery	$40 Copayment not subject to Deductible		
Preauthorization; Referral Required			

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder *Preauthorization; Referral Required*	$25 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder *Preauthorization; Referral Required*	$25 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Insulin (30-Day Supply)	$25 Copayment not subject to Deductible		
Diabetic Education *Preauthorization; Referral Required for Insulin Pump*	$25 Copayment not subject to Deductible		
Durable Medical Equipment & Braces *Preauthorization required for items costing more than $500; Referral Required*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
External Hearing Aids *Referral Required*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants *Referral Required*	Covered in Full not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care		Non-Participating Provider services are not covered and You pay the full cost	
Inpatient	20% Coinsurance after Deductible		Five (5) visits for family bereavement counseling
Outpatient *Preauthorization; Referral Required*	$40 Copayment not subject to Deductible		
Medical Supplies *Preauthorization; Referral Required*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prosthetic Devices		Non-Participating Provider services are not covered and You pay the full cost	
External	Covered in Full not subject to Deductible		One (1) prosthetic device, per limb, per lifetime
Internal *Preauthorization; Referral Required*	Covered in Full not subject to Deductible		Unlimited See benefit for description

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Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) *Preauthorization; Referral Required. However, Preauthorization is not Required for Emergency Admissions.*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Observation Stay *Preauthorization; Referral Required*	$400 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) *Preauthorization; Referral Required*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	200 days per Calendar Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) *Preauthorization; Referral Required*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	60 days per Calendar Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	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) *Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) *Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions*	$40 Copayment not subject to Deductible for Outpatient Mental Health Care; Partial Hospitalization & Intensive Outpatient Program Services are Covered in Full after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) *Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions*	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Outpatient Substance Use Services *Preauthorization; Referral Required*	$40 Copayment not subject to Deductible for Outpatient Mental Health Care; Partial Hospitalization & Intensive Outpatient Program Services are Covered in Full after Deductible	Non-Participating Provider services are not covered and You pay the full cost	Unlimited; Up to 20 visits per calendar year may be used for family counseling

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Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Tier 1	$5 Copayment not subject to Deductible		
Tier 2	$65 Copayment not subject to Deductible		
Tier 3	50% Coinsurance to a maximum of $800 not subject to Deductible		
Mail Order Pharmacy			
30 Day Supply		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Tier 1	$5 Copayment not subject to Deductible		
Tier 2	$65 Copayment not subject to Deductible		
Tier 3	50% Coinsurance to a maximum of $800 not subject to Deductible		
31 - 90 Day Supply		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Tier 1	$13 Copayment not subject to Deductible		
Tier 2	$163 Copayment not subject to Deductible		
Tier 3	50% Coinsurance to a maximum of $2,000 not subject to Deductible		
Enteral Formulas		Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Tier 1	$5 Copayment not subject to Deductible		
Tier 2	$65 Copayment not subject to Deductible		
Tier 3	50% Coinsurance to a maximum of $800 not subject to Deductible		

Wellness Benefits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Gym Reimbursement	Not Applicable	Not Applicable	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care		Non-Participating Provider services are not covered and You pay the full cost	One (1) dental exam and cleaning per six (6)-month period
Preventive Dental Care	Covered in Full after Deductible		
Routine Dental Care	20% Coinsurance after Deductible		

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Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			
Major Dental (Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Deductible		
Orthodontics	50% Coinsurance after Deductible		
Orthodontics Require Preauthorization; Referral			
Pediatric Vision Care		Non-Participating Provider services are not covered	
Exams	$25 Copayment not subject to Deductible	and You pay the full cost	One (1) exam per 12-month period;
Lenses & Frames	50% Coinsurance not subject to Deductible		One (1) prescribed lenses and frames in a 12-month period
Contact Lenses	50% Coinsurance not subject to Deductible		

Contact Lenses Require Preauthorization; Referral

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of the services.

Women's Health and Cancer Rights Act

As required by the *Women's Health and Cancer Rights Act of 1998*, benefits are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of 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 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments, coinsurance and any annual deductible) and the benefit coverage limitations are the same as are required for any other covered health service as described in your Certificate of Coverage or Summary Plan Description.

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 precertification. For information on precertification, call the toll-free Customer Service telephone number on your Oxford member ID card.

Notification of Language Assistance Program

We understand that we serve an increasingly diverse membership. More than ever, we believe that it is important to accommodate language preferences, especially when it comes to our members accessing care and services to ensure that language is not an obstacle to receiving proper care.

We offer language assistance services to limited English proficiency (LEP) members. Language assistance services are provided free of charge to members. If you need assistance or have any questions about these services, please call the toll-free Customer Service telephone number on the back of your Oxford member ID card.

This is Your

EXCLUSIVE PROVIDER ORGANIZATION

CERTIFICATE OF COVERAGE

Issued by

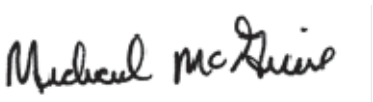
Oxford Health Insurance, Inc.

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 listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

In-Network Benefits. This Certificate only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Metro network. Care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive the benefits under this Certificate, You must contact Your Primary Care Physician before You obtain the services except for services to treat an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Certificate, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

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.



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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.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost Sharing Expenses and Allowed Amount Section of this Certificate for a description of how the Allowed Amount is calculated.

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

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

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

Certificate: This Certificate 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): 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.

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

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

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

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

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

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

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes

one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

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

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

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

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

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

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

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

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and

- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

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

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

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

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

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

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

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

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

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

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

Plan Year: The 12-month period beginning on the effective date of the Policy or any anniversary date thereafter, during which the Policy is in effect.

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

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

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

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 a Referral will not be made to a Non-Participating Provider.

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

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

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

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

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

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

Subscriber: The person to whom this Certificate is issued.

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

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a 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 (including 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;
- 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 Your Provider directory, available at Your request;
- Call the number on your ID card; or
- Visit Our website at www.oxhp.com.

D. **The Role of Primary Care Physicians.** This Certificate has a gatekeeper, usually known as a Primary Care Physician ("PCP"). You need a written Referral from a PCP before receiving Specialist care. You may select any participating PCP who is available from the list of PCPs in the EPO Metro. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

1. **Services Not Requiring a Referral from Your PCP.** Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital emergency Medical Services and emergency ambulance transportation;

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

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

2. **Access to Providers and Changing Providers.** Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is accepting new patients.

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

   You may change your PCP by 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. This can be done at any time and the change will be effective immediately.

   You may change your Specialist by asking your PCP to refer you to another Network Specialist of your choice. This can be done at any time. The change will be effective upon your PCP issuing a new referral.

E. **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.

F. **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.

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

We may base Our decision on a review of:

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

Services will be deemed Medically Necessary only if:

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

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

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

H. **Protection from Surprise Bills.**

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

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

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

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

the Non-Participating Physician may only bill You for Your Copayment, Deductible or Coinsurance.

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

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. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

I. **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 by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

J. **Case Management.**

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

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

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

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

K. **Important Telephone Numbers and Addresses**.

CLAIMS

Refer to the address on Your ID card

*Submit claim forms to this address.

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

Call the number on Your ID card

Assignment of Benefits Form

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

MEDICAL EMERGENCIES AND URGENT CARE

Call the number on Your ID card

Monday- Friday 8:00 AM to 6:00PM

Evenings, Weekends and Holidays: 1-800 201-4911

CUSTOMER SERVICE

Call the number on Your ID card

* Customer Service Representatives are available

Monday- Friday 8:00 AM to 6:00PM.

PREAUTHORIZATION

Call the number on Your ID card

OUR WEBSITE

www.oxhp.com

Section III - Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

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

B. When a Specialist Can Be Your Primary Care Physician.

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

C. Standing Referral to a Participating Specialist.

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

paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.

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

E. When Your Provider Leaves the Network.

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

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

F. New Members In a Course of Treatment

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

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

Section IV - Cost-Sharing Expenses and Allowed Amount

A. **Deductible**. There is no Deductible for Covered Services under this Certificate during each Plan 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. Cost-Sharing for out-of-network services does not apply toward Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

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

C. **Coinsurance.** Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate.

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

E. **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.

Our payments to Participating Providers may include financial incentives to help improve the quality 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 Services 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.

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

Section V - Who Is Covered

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

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, foster 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 year in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Grandchildren are not Covered.

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

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

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

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days from the date of 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 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the 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; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

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 a state child health plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

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 Customer Service number on your ID card or visit Our website at www.oxhp.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 well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

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, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.oxhp.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 Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

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

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.oxhp.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

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

Section VII – Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization 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. We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service.

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

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

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

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

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

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

- From a non-participating Hospital to a participating Hospital;

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

C. Limitations/Terms of Coverage.

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

Section VIII - Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization 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**. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

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

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

   We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless We authorize continued treatment at the non-participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and arranged for a transfer to a participating Hospital will not be Covered.

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

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

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

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

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

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

Section IX - Outpatient and Professional Services

(for other than Mental Health and Substance Use)

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

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. We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

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.

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

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

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 for up to 60 visits per plan year. The visit limit applies to all therapies combined.

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

Home Health Care is limited to 40 visits. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

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

1. Basic Infertility Services. Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services.

Basic infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and

- Medically appropriate treatment of ovulatory dysfunction.

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

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

   Comprehensive infertility services include:

   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Exclusions and Limitations.** We do not Cover:

   - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Cryopreservation and storage of embryos;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
   - 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.

K. Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or

other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Interruption of Pregnancy. We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We Cover elective abortions.

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 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 the cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding.

O. Medications for Use in the Office or Outpatient Facilities. We Cover medications and injectables (excluding self-injectables used by Your Provider in the Provider's office or 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 Prescription Drug Coverage section of this Certificate.

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

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

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

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Rehabilitation Services. We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to 60 visits per plan year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

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

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

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

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

T. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written Referral to a non-participating Specialist.
2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.
3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.

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

4. Second Opinions in Other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

U. Surgical Services. We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

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

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

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

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.

- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

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

X. Other Reconstructive and Corrective Surgery. We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

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

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

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

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.

Section X - Additional Benefits, Equipment and Devices

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

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

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

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

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

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the

maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

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

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

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

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

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

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

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

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

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Blood glucose kit
- Blood glucose strips (test or reagent)
- Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired

- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose reagent strips
- Glucose reagent tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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

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

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

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

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

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

D. 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 years.

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

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

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one (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.

E. 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; homemaker, caretaker, or respite care.

F. 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.

G. Prosthetics.

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

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

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

(for other than Mental Health and Substance Use)

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

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 plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

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

B. Observation Services. We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician

decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

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

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

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

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

G. Rehabilitation Services. We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for up to 60 days per calendar year.

We Cover speech and physical therapy only when:

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

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

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

H. Skilled Nursing Facility. We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the “Exclusions and Limitations” section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days, per Calendar Year, for non-custodial care.

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

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

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

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

- Bariatric surgery;
- Transplants.

K. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private

room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.

2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

Section XII - Mental Health Care and Substance Use Services

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

A. Mental Health Care Services.

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

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

   and, in other states, to similarly licensed or certified Facilities.

   We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care incudes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in

other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; 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.

3. **Limitations/Terms of Coverage.** We do not Cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

B. Substance Use Services.

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

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including methadone treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance

abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

Section XIII - Prescription Drug Coverage

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. 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.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.

- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

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

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

C. Benefit and Payment Information.

1. **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 or 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.

An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your Out-of-Pocket Limit.

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

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

   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

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

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

3. **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.

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

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited

availability, special dispensing and delivery requirements and/or require additional patient supports.

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

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

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

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

5. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order supplier. You are responsible for paying the lower of:

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

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

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

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

   For maintenance Prescription Drugs, You may obtain Your first two (2) Prescription Orders at a retail Participating Pharmacy. After Your first two (2) Prescription Orders, you must obtain maintenance Prescription Drugs from Our mail order pharmacy or You must opt out of obtaining Your maintenance Prescription Drugs from Our mail order pharmacy. You may opt out by visiting Our website at www.oxhp.com or by calling the number on your ID card. You must opt out on an annual basis for each different prescription drug.

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

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.oxhp.com or by calling the number on Your ID card. The maintenance drug list is updated periodically. Visit Our website or call the number on your ID card to find out if a particular drug is on the maintenance list.

6. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per calendar

year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.oxhp.com or by calling the number on Your ID card.

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

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

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

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

from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

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

   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 amounts 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 or call 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.oxhp.com or by 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 Appeals sections of this Certificate.

10 **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits 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.

11. **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.oxhp.com or by calling the number on Your ID card.

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

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

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.oxhp.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drug before We will Cover another as Medically Necessary. 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.

E. Limitations/Terms of Coverage.

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

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

3. Compounded Prescription Drugs will be Covered only when they contain at least one 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 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 or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.
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.

F. General Conditions.

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

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

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

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

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

3. Formulary: The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per calendar year). You may determine to which tier a particular

Prescription Drug has been assigned by visiting Our website at www.oxhp.com or by calling the number on Your ID card.

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

5. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members.

6. **Participating Pharmacy:** A pharmacy that has:

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

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

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

8. **Prescription Drug Cost:** The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your 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.

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

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

Section XIV - Wellness Benefits

A. Exercise Facility Reimbursement.

We will partially reimburse the Subscriber and the Subscriber's covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.

In order to obtain reimbursement, at the end of the six (6)-month period You must submit:

- A completed reimbursement form.
- A copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's covered Spouse or the actual cost of the membership per six (6)-month period. Reimbursement will be issued only after You have completed each six (6)-month period even if 50 visits are completed sooner.

B. Wellness Program.

1. **Purpose.** The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.
2. **Description.** We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:
    - A health risk assessment tool
    - A designated smoking cessation program
    - A designated weight management program
    - A designated stress management program
    - A designated worker injury prevention program
    - A designated health or fitness incentive program

- Designated online wellness activities
- Designated healthy activities
- Self-management of chronic diseases

3. **Eligibility.** You, the Subscriber, and the Subscriber's covered Spouse can participate in the wellness program.
4. **Participation.** The preferred method for accessing the wellness program is through our website. 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 number on Your ID card and we will provide You with information regarding how to participate without internet access.
5. **Rewards.** Rewards for participation in a wellness program include:
   - Full or partial reimbursement of the cost of membership in a health club or fitness center.
   - The waiver or reduction of Copayments, Deductibles or Coinsurance.
   - Monetary rewards in the form of cash, 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.
   - Merchandise, so long as the item is geared at promoting good health, such as healthy cookbooks or nutritional or exercise equipment.

C. Rally Program.

1. **Purpose.** Rally is a health and wellness tool that applies digital experiences, tools, games and rewards and is designed to engage Members in managing their health.
2. **Description.**
   A. **Wellness Opportunities.** The health and wellness tool includes a wide range of wellness engagement opportunities. Engagement opportunities include, but are not limited to, the following:
      - Interactive social media and games, which may include participation in wellness challenges and health communities.
      - Health Survey.
      - Online Personal Health Record.
      - Invitation to create personal missions.
      - Integration with a variety of wellness devices (for example, wearable wireless trackers and mobile tools).

B. **Missions.** Rally offers dozens of different missions from which Members can choose to personalize their experience. These missions ask users to focus on small behavioral changes such as cooking at home more, sticking to a regular bedtime routine or walking a certain number of miles per day. The missions fall into three broad health and wellness categories:

- Exercise.
- Healthy eating.
- Mental wellness.

The Member can select any number of missions to complete. For example, the mental wellness missions include keeping a mood diary, shutting off electronic devices before bed or getting at least seven hours of sleep a night. The missions are strictly voluntary, and based on the Member's self-reported progress, Members can earn coins for completing daily, weekly, and monthly check-in goals.

3. **Eligibility.** Participation is available to Covered Persons age 13 years and older, however wellness rewards are only available to Members age 18 years and older.

4. **Rewards.** Members, age 18 years and older, receive wellness rewards for participation in health and wellness opportunities as described above. When a Member participates in a health and wellness opportunity, the Member earns "coins" as a reward for their participation. For example, a Member may earn 40 coins for completing a health survey. Coins can be accumulated and the Member may use their coins to enter into sweepstakes.

   Sweepstakes winners are randomly selected and the value of sweepstake rewards range from $20 - 600.

   The expected odds of winning each sweepstakes depend on the number of entries for that sweepstakes. Rally weights each entry equally; each has the same chance of winning. Unless your employer group sets up its own pool, Rally draws winning entries from all members who have submitted a sweepstakes entry, regardless of that entrant’s employer group, state, or region.

   Historically, Rally has randomly drawn one winner from all eligible entries for that sweepstakes. Rally, however, can increase the number of reward winners, and reserves its right to do so to ensure that its user base is incentivized to engage in missions and challenges that encourage healthy behavior.

   If you are unable to meet a standard for certain wellness rewards, then you might qualify for an opportunity to earn the same reward by different means. You may contact us at 1-855-215-0230 and we will work with you (and, if

necessary, with your doctor) to find another way for you to earn the same reward

Section XV - Pediatric Vision Care

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

A. Pediatric Vision Care. We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

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

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

C. Prescribed Lenses and Frames. We Cover standard prescription lenses or contact lenses for Members through the end of the month in which the Member turns 19 years of age, one (1) time in any 12 month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames for Members through the end of the month in which the Member turns 19 years of age, adequate to hold lenses one (1) time in any 12 month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

We do not Cover prescribed lenses and frames for Members after the end of the month in which the Member turns 19 years of age.

Section XVI - Pediatric Dental 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.

We Cover the following dental care services for Members through the end of the month in which the Member turns 19 years of age:

A. Emergency Dental Care. We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care. We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36 month intervals, bitewing x-rays at six (6) to 12 month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover periodontic services, including periodontic services in anticipation of, or leading to orthodontics Covered under this Certificate.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

Section – XVII 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. 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.

D. 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.

E. 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 and Pediatric Dental Care sections of this Certificate.

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

treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation. We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

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

I. Government Facility. We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

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

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

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

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

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

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

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

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

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

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

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

Section XVIII - Claim Determinations

A. **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. **Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at www.oxhp.com.Completed claim forms should be sent to the address in the How Your Coverage Works of this Certificate or on Your ID card. You may also submit a claim to Us electronically by visiting our website at www.oxhp.com.

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

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

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

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received.

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

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

2. **Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

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

Section XIX – 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 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.

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 a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for service.)	In writing, within 30 calendar days of receipt of Your Grievance.

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 2 business days of receipt of the 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 a 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 service.)	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

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 XX - Utilization Review

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

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

B. Preauthorization Reviews.

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

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

2. **Urgent Preauthorization Reviews._**With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and

Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period.

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 one (1) business day 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) 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) 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 time 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.

D. Retrospective Reviews.

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

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

E. 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. 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.

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

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

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. You are not eligible for a Utilization Review Appeal if the service You request is available from a Participating Provider, even if the Non-Participating Provider has more experience in diagnosing or treating Your condition. (Such an Appeal will be treated as a Grievance.) For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:

   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the Out-of-Network service: 1) Is likely to be more clinically beneficial to You than the alternate In-Network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for 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 Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

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

H. 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, 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.

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

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

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

I. 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.

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

Community Health Advocates

633 Third Avenue, 10th Floor
New York, NY 10017

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

Website: www.communityhealthadvocates.org

Section XXI - External Appeal

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

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

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

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

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

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

1. Standard health services are ineffective or medically inappropriate; **or**

2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**

3. There exists a clinical trial or rare disease treatment (as defined by law).

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

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

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

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

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

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

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

E. Your Right to Appeal an Out-of-Network Referral Denial. 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: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

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

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

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

We will provide an external appeal application with the final adverse determination issued through 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 Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

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

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

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

We will charge You a fee of $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 XXII – Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments. We do not coordinate benefit payments for pediatric vision benefits.

A. Definitions.

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

2. **"Plan"** is other group health coverage with which We will coordinate benefits. The term "plan" includes:

   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

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

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

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

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination. When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We

would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

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

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

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. 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.

Section XXIII – 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 end of month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the year in which the Child turns 26 years of age.
6. For all other Dependents, the end of month in which the Dependent ceases to be eligible.
7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.
9. The date that the Group Policy is terminated. If We terminate and/or 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 elect to terminate or cease offering all hospital, surgical and medical expense coverage in the small group market in this state, We will provide written

notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.

11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
12. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
13. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
14. The date there is no longer any enrollee 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 for Your right to conversion to an individual Policy.

Section XXIV –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 XXV - 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;
   - c. 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 policyholder.

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 his or her own individual 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 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 the 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 XXVI - 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 Section XI – Termination of Coverage 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 Contract. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract. We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage. 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 XXVII - 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 to any person, corporation, or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill . See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment by You other than monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. **Changes in this Certificate.** We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

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

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

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

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

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

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974, (“ERISA”). 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 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 Customer Service 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, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
    - Written application procedures and minimum qualification requirements for Providers.
18. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to 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 will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

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

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

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

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

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

23. **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.

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

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

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

25. **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.

26. **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.

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

28. **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.

29. **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.

30. **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.

31. **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 regardless of whether an assignment has been made.

32. **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.

38. **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, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may

engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

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

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

39. **Your Rights.** You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

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

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

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

Section XXVIII - Other Covered Services

A. Hemophilia

Hemophilia: *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 clotting factor are available only when provided by the specific participating Providers listed below:

1. Prescription Drug Coverage for clotting factor provided by a Participating Hemophilia Treatment Center

   We Cover clotting factors that you self-administer or is administered by a non-skilled caregiver when it would otherwise be covered under your Prescription Drug benefits and it is dispensed by a Participating Hemophilia Treatment Center as part of your written treatment plan. This Covered Service will be provided in lieu of receiving clotting factor dispensed by a Designated Pharmacy under your Prescription Drug Coverage benefit. A “Hemophilia Treatment Center” (HTC) means a unique federally funded entity that specializes in comprehensive care for pediatric and adult individuals with inherited bleeding and clotting disorders. An HTC must be a licensed Facility that is also designated as a comprehensive hemophilia diagnostic treatment center receiving a grant under Section 501(a) (2) of the Social Security Act and participates in the 340B Drug Pricing Program.

   Your Cost-Sharing for clotting factor 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 Factor

   In addition to the Home Health Care Benefits available under Your Certificate, we will Cover non-emergent administration of clotting factor 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 clotting factor 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 clotting factor 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 clotting factor. It does not Cover clotting factor 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.

* *Some bleeding disorders, such as hemophilia, can be inherited or acquired. Others can occur from such conditions as anemia, cirrhosis of the liver, HIV, leukemia and vitamin K deficiency. They also can result from certain medications that thin the blood, including aspirin, heparin and warfarin.*

Treatment for bleeding disorders varies, depending on the condition and its severity. For some bleeding disorders, there are clotting factor concentrates that can be infused prophylactically or on-demand at home, to prevent or treat bleeds. For other bleeding disorders, there are topical products, nasal sprays and fresh frozen plasma, which is administered in a hospital setting.

B. Additional Network Availability

Certain Covered Services defined below may also be provided through the W500 Network. Go to www.oxhp.com or contact Customer Care for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Services are received from providers who are contracted with us through the W500 Network.

These Covered Services are limited to the following:

- Emergency Services as described in the Emergency Services and Urgent Care section of this Certificate.

- Hospital Services for an inpatient stay when you are admitted to the Hospital on an unscheduled basis because of an Emergency.
- Urgent care services provided as described under the Emergency Services and Urgent Care section of this Certificate.

Also, if we determine that specific Covered Services are not available from a Metro Network provider, you may be eligible for Network Benefits when Covered Services are received from a W500 Network provider. In this situation, before you receive these Covered Services, your Metro Network Physician will notify us and, if we confirm that the Covered Services are not available from a Metro Network provider, we will work with you and your Metro Network Physician to coordinate these Covered Services through a W500 Network provider.

UnitedHealthcare®
Oxford

ACCESS REQUEST FORM

Purpose: This Form is intended for use by an individual to exercise his/her right to access his/her protected health information in Oxford's designated record sets or the designated record sets of Oxford's business associates.

Individual Seeking Access

Name: _____

Address: _____

Oxford I.D. Number: _____

Telephone: _____

Scope of Access

You have the right to inspect and obtain a copy of your protected health information maintained by Oxford and its business associates. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have or any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding.

Please specify the records you wish to inspect or obtain copies of:

_____

_____

_____

We may charge you to make copies and mail your protected health information. Oxford will notify you in advance of these charges. If you want to pick the copies up at our Shelton, CT office please check here _____

Signature: _____ **Date**: _____

Personal Representative

If this request is being made by a personal representative on behalf of the individual, please provide a description and any available documentation of authority to act as the individual's personal representative and sign below.

_____

_____

Print name _____

Signature _____

Please send completed form to:

Oxford Health Plans
Attn: HIPAA Member Rights Unit
P.O. Box 29135
Hot Springs, AR 71903

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

Domestic Partner Rider

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

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

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

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

RIDER TO MODIFY THE DEFINITION OF PLAN YEAR

The definition of Plan Year in Section I - Definitions of Your Certificate is deleted and replaced with the following language:

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect. However, Your Deductible and Your Out-of-Pocket Limit accumulate on a calendar year.

www.oxfordhealth.com