

State: New York **Filing Company:** Oxford Health Plans (NY), Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005B Individual - Point-of-Service (POS)
Product Name: 2015 OHP IND OFFX Plans
Project Name/Number: 2015 OHP IND OFFX Plans/

Filing at a Glance

Company: Oxford Health Plans (NY), Inc.
Product Name: 2015 OHP IND OFFX Plans
State: New York
TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI: HOrg02I.005B Individual - Point-of-Service (POS)
Filing Type: Prior Approval Off Exchange Form & Rate Filing
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Author(s): [REDACTED]
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State Filing Description:

State: New York Filing Company: Oxford Health Plans (NY), Inc.
 TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
 Product Name: 2015 OHP IND OFFX Plans
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General Information

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Filing Description:
 2015 OHP Individual Off Exchange Plans

Company and Contact

Filing Contact Information

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 Trumbull, CT 06611 [REDACTED]

Filing Company Information

Oxford Health Plans (NY), Inc. CoCode: 95479 State of Domicile: New York
 One Penn Plaza FL 8 Group Code: Company Type: HMO
 New York, NY 10119 Group Name: State ID Number: 95479
 [REDACTED] FEIN Number: 06-1181200

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State Specific

1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): Yes - OHP Ind Off Exch Form Filing, 6/13/14, SERFF Tr Num: UHLC-129590054
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Yes - Statutory Individual HMO and POS
4. Type of filing? Enter Form and Rate, Form only, Rate only (Form only should be used ONLY when the filing only contains an application, advertisement, administrative form, or is a group pre-filing notification, out-of-state, or a report filing. Form

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submissions with no proposed rate impact are considered form and rate filings and require an actuarial memorandum.): Rate Only

5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): Yes - Prior Approval Rate Adjustment

6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No

7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No

8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No

9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No

10. If this is a rate adjustment filing pursuant to Section 3231(e)(1) or 4308(c), did this insurer submit a "Prior Approval Prefiling" containing a draft narrative summary, a draft initial notification letter, and a draft numerical summary associated with this filing? Yes/No (If Yes, enter the state tracking number and the SERFF tracking number of the prefile.): Yes - State Tr Num: 2014060105, SERFF Tr Num: UHLC-129575078

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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Certificate of Coverage	OHPNY_IND_COC_2015	CER	Initial		45.100	Draft_OHPNY_Ind_2015_COC_clean.pdf
2		Certificate of Coverage	OHPNY_IND_COC_CHILD_2015	CER	Initial		45.100	Draft_OHPNY_Ind_2015_COC_Child_Only_clean.pdf
3		Out-of-Network Rider	OHPNY_IND_RDR_ONET_2015	CERA	Initial		45.100	Draft_OHPNY_Ind_2015_RDR_ONET_clean.pdf
4		Schedule of Benefits	OHPNY_IND_SBN_SILVER_2015	SCH	Initial		46.300	Draft_OHPNY_Ind_2015_SBN_Silver_HMO_clean.pdf
5		Schedule of Benefits	OHPNY_IND_SBN_GOLD_2015	SCH	Initial		46.300	Draft_OHPNY_Ind_2015_SBN_Gold_HMO_clean.pdf
6		Schedule of Benefits	OHPNY_IND_SBN_PLATINUM_2015	SCH	Initial		46.300	Draft_OHPNY_Ind_2015_SBN_Platinum_HMO_clean.pdf
7		Schedule of Benefits	OHPNY_IND_SBN_BRONZE_2015	SCH	Initial		46.300	Draft_OHPNY_Ind_2015_SBN_Bronze_HMO_clean.pdf
8		Schedule of Benefits	OHPNY_IND_SBN_PLATINUM_POS_2015	SCH	Initial		46.300	Draft_OHPNY_Ind_2015_SBN_Platinum_POS_clean.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage

SERFF Tracking #:

UHLC-129581419

State Tracking #:

2014060277

Company Tracking #:

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OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

This is Your
HEALTH MAINTENANCE ORGANIZATION CONTRACT
Issued by
Oxford Health Plans (NY), Inc.

This is Your individual direct payment Contract for health maintenance organization coverage issued by Oxford Health Plans (NY), Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Examine it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. Refer to the Termination of Coverage section of this Contract for the renewal provisions.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Compass network. Care Covered under this Contract (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 Contract, 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 Contract. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

[\[¹Officer Signature\]](#)

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Section I - Definitions

Defined terms will appear capitalized throughout this Contract.

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 Contract 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.

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 Contract.

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.

Contract: This Contract issued by Oxford Health Plans (NY), Inc., including the Schedule of Benefits and any attached riders.

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 or arranged for You by Us under the terms and conditions of this Contract.

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
- As 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(1) 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.

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; 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 Contract.

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 rehabilitatory 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 Contract 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 [²XXX] or upon Your request to Us. The list will be revised from time to time by Us.

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

Plan Year: A calendar year ending on December 31 of each year.

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

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 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.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Contract 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 Contract that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Bronx, Dutchess, 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 and a domestic partner.

Subscriber: The person to whom this Contract 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 Plans (NY), Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

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

You, Your: The Member.

Section II - How Your Coverage Works

- A. **Your Coverage Under this Contract.** You have purchased a HMO Contract from Us. We will provide the benefits described in this Contract to You and Your covered Dependents. You should keep this Contract 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 Contract 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 Contract; and
 - Received while Your Contract is in force.

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

- C. **Participating Providers.** To find out if a Provider is a Participating Provider:
- Check Your Provider directory, available at Your request;
 - Call the number on Your ID card; or
 - Visit our website at [²XXX].
- D. **The Role of Primary Care Physicians.** This Contract 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 HMO Compass Network. Each Member may select a different PCP. Children covered under this Contract 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 Contract 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 Contract 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 Contract for the services that require a Referral.

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

To see a Provider, call his or her office and tell the Provider that you are an Oxford Health Plans (NY), Inc. Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your 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 Contract 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 Contract 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.

See Section IX – Grievance, Utilization Review & External Appeals of this Contract 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 provided on or after April 1, 2015 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.

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.

I. **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

J. Important Telephone Numbers and Addresses.

▪ **CLAIMS**

[³XXX-XXX-XXXX]

*(Submit claim forms to this address.)

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

[³XXX-XXX-XXXX]

▪ **MEDICAL EMERGENCIES AND URGENT CARE**

[³XXX-XXX-XXXX]

[³Monday - Friday 8:00 a.m. - 5:00 p.m.]

[³Evenings, Weekends and Holidays]

▪ **CUSTOMER SERVICE**

[³XXX-XXX-XXXX]

*(Customer Service Representatives are available [⁴Monday – Friday 8:00 a.m. – 5:00 p.m.]

▪ **PREAUTHORIZATION**

[³XXX-XXX-XXXX]

▪ **OUR WEBSITE**

[²XXX]

Section III - Access to Care and Transitional Care

- A. Referral to a Non-Participating Provider.** Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, 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 only be responsible 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 Contract 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 Contract. 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 Contract 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

⁵A. **Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.]

⁶A. **Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Benefits section of this Contract for Covered in-network Services under this Contract during each Plan Year before We provide coverage for any person covered under this Contract. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.]

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

- B. **Copayments.** Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.
- C. **Coinsurance.** Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Contract.
- 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 Contract, 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 Contract. 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 Contract

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 Contract, 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 Contract, 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.

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

Section V - Who is Covered

A. Who is Covered Under this Contract. You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. If You are enrolled in Medicare, You are not eligible to purchase this Contract. Members of Your family may also be covered depending on the type of coverage you selected.

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

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

C. Children Covered Under This Contract. If You selected parent and child/children or family coverage, Children covered under this Contract 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 [7 the end of the [month; year] in which] the Child turns [826] years of age. Coverage also includes Children for whom You are a [9permanent] 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 Contract at any time.

- D. Open Enrollment.** For Plan Years beginning on or after January 1, 2015, You can enroll under this Contract during an open enrollment period that runs from November 15, 2014, through February 15, 2015. If We receive Your selection on or before December 15, 2014, Your coverage will begin on January 1, 2015, as long as the applicable premium payment is received by then. If We receive Your selection between the dates of December 16, 2014, through January 15, 2015, Your coverage will begin on February 1, 2015, as long as the applicable premium payment is received by then. If We receive Your selection between the dates of January 16, 2015, through February 15, 2015, Your coverage will begin on March 1, 2015, as long as the applicable premium payment is received by then.

For Plan Years beginning on or after January 1, 2016, You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If We receive Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

- E. Special Enrollment Periods.** Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses minimum essential coverage;
2. Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the NYSOH.;
3. You adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract;
4. You move and become eligible for new health plans;
5. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption;
6. You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
7. You, Your Spouse or Child exhausted Your COBRA or continuation coverage.

We must receive notice and premium payment within 60 days of one of these events.

If You enroll because You lost minimum essential coverage or because You got married, Your coverage will begin on the first day of the month following Your loss of coverage or marriage.

If You have a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which We receive notice and the premium payment.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection 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, as long as Your applicable premium payment is received by then.

F. Domestic Partner Coverage. This Contract covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Contract also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
 - a. The affidavit must be notarized and must contain the following:
 - The partners are both eighteen 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;

- 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; and
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Section VI – Preventive Care

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

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on your ID card or visit Our website at [²XXX] 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.
- 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 [²XXX], 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.

- 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.
- 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 [²XXX], 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.
- E. Mammograms.** We Cover mammograms for the screening of breast cancer as follows:
- One baseline screening mammogram for women age 35 through 39; and
 - One 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.

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 and Reproductive Health Services.** We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of the Contract, 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.

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 the Contract. 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;
- 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.

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.

Section VII - Pre-Hospital Emergency Medical Services and Ambulance Services

Please refer to the Schedule of Benefits section of this Contract 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 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 of the following is met:
 - ♦ The point of pick-up is inaccessible by land vehicle; or
 - ♦ Great distances or other obstacles (for example, 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 Contract 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 in this Contract and 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.

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

- B. Urgent Care.** Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as

to require Emergency Department Care. **Urgent Care is Covered in or out of Our Service Area.**

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

I. Home Health Care. We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;

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

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is considered one 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 :

- ◆ 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);
- ◆ Sex change procedures;
- ◆ 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 into the muscles 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 for one procedure per Member, per Plan Year.
- 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 Contract for Coverage of inpatient maternity care.
- We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.
- O. Medications for Use in the Office.** We Cover medications and injectables (excluding self-injectables used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of the Contract.
- 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 Contract 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 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.

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 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 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 Contract 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, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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, laptops, 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 an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "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.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

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 Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
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 Contract.
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 the Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Contract for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. Any Copayment, Deductible or Coinsurance that applies to office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Contract 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 Jump
- ◆ 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 will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

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

2. Braces. We Cover braces 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 or both ears once every three (3) 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 hearing aid per ear during the entire period of time that You are enrolled under this Contract. 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 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 Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. 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 of this Contract 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 Contract and are only Covered under the Pediatric Vision Care section of this Contract.

We do not Cover orthotics.

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

Coverage is for standard equipment only.

- ♦ **External Prosthetic Devices for Adults.** For adults, We Cover the cost of one prosthetic device, per limb, per lifetime. We do not Cover the cost of repair or replacement.
 - ♦ **External Prosthetic Devices for Children.** For children, We Cover the cost of one prosthetic device, per limb, per lifetime. We Cover the cost of replacement for children but only if the previous device has been outgrown. We do not Cover the cost of repairs.
- 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 Contract 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 Contract 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 Contract.
- 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 Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Contract 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 Plan 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 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 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 Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. ¹⁰We Cover up to 200 days, per Plan 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 Contract until the External Appeal Agent renders a decision in Our favor.

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

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care service 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 Contract 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 Contract. 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 Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the 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 alcoholism, substance use and dependency. 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 alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; 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 alcoholism, substance use and dependency, 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 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 and/or dependency; and 2) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use and/or dependency. 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 Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Outpatient 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 Contract.
- 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.
- Prescription Drugs for smoking cessation.
- 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 [²XXX]. You may inquire if a specific drug is Covered under this Contract 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 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 XIV – Schedule of Benefits of this Contract.

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 Contract when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

You have a three 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 [²XXX] 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:

- ◆ ¹¹Age 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 [\[²XXX\]](#) 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 [\[²XXX\]](#) 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 Prescription 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 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 [²XXX] or by calling the number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic.** When a Brand-Name Drug becomes available as a Generic, 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 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 Contract.
8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You may request a Formulary exception for a clinically-appropriate Prescription Drug. Visit Our website at [²XXX] or call the number on your ID card to find out more about this process.
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 Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at [²XXX] or by calling the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Contract.
9. **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 in Section XIV – Schedule of Benefits of this Contract 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 Contract.
10. **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 [²XXX] or by calling the telephone number on Your ID card.

D. Medical Management. This Contract 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 [²XXX] 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 of 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 Contract. 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 type 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 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 Contract.
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 Contract.
7. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Contract. 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 Contract.

13. 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, 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 Contract).

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 Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at [2XXX] 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. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
6. **Participating Pharmacy:** A pharmacy that has:
 - ◆ Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
 - ◆ Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
 - ◆ Been designated by Us as a Participating Pharmacy.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 Contract 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-month period.

In order to obtain reimbursement, at the end of the six-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 Spouse or the actual cost of the membership per six-month period.

Section XV - Pediatric Vision Care

Please refer to the Schedule of Benefits section of this Contract 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 up to age 19.
- B. Vision Examinations.** We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
- Case history;
 - External examination of the eye or internal examination of the eye;
 - Ophthalmoscopic exam;
 - Determination of refractive status;
 - Binocular distance;
 - Tonometry tests for glaucoma;
 - Gross visual fields and color vision testing; and
 - Summary findings and recommendation for corrective lenses.
- C. Prescribed Lenses & Frames.** We Cover standard prescription lenses or contact lenses for Members up to age 19, one (1) time in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation.

We do not Cover prescribed lenses and frames for Members over the age of 18.

Section XVI - Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Contract 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 up to age 19:

- 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 thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (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 Contract.
- 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

No coverage is available under this Contract 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 Contract. 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 Contract 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 except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care section of this Contract.
- 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 Contract, 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 the Contract for non-investigational

treatments. See the Utilization Review and External Appeal sections of this Contract 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 unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.
- J. Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Contract.
- 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).
- 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 Contract 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 Contract.
- S. War.** We will 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 Contract. 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.
- 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 [²XXX]. Completed claim forms should be sent to the address in the How Your Coverage Works of this Contract or on Your ID card. Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, You may also submit a claim to Us electronically by sending it to the e-mail on Your ID card or visiting Our website at [²XXX].
- 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 days 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 section of this Contract.
- For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.
- 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 time period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.

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

Section IX – Grievance Procedures

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

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

We keep all requests and discussions confidential and We'll 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 a service.)

In writing, within 30 calendar days of receipt of Your Grievance.

- D. Assistance.** If You remain dissatisfied with Our Grievance determination or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:

New York State Department of Health

Corning Tower

Empire State Plaza

Albany, NY 12237

www.health.ny.gov

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

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: 1-888-614-5400

Or e-mail cha@cssny.org

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 Provider who typically manages Your medical condition or disease or provides the health care service under review. 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 [2XXX].

B. Preauthorization Reviews.

1. 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 time period.

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.

C. Concurrent Reviews.

1. 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 time period.

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

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

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 before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. 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.** Beginning April 1, 2015, You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition:
 - ♦ That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
 - ♦ Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

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

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.

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

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: 1-888-614-5400

Or e-mail cha@cssny.org

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 does not meet Our requirements for Medical Necessity (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 requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Contract; 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 does not meet Our requirements for Medical Necessity, 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 requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:
- Standard health services are ineffective or medically inappropriate; **or**
 - There does not exist a more beneficial standard service or procedure covered by Us; **or**

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

In addition, Your attending Physician must have recommended one 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 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.

You do not have a right to an external appeal for a denial of a Referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by You.

- E. Your Right to Appeal an Out-of-Network Referral Denial.** Beginning on April 1, 2015, if We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two 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. The External Appeal Process.** You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

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

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

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your

attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment We will provide coverage subject to the other terms and conditions of this Contract. 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 Contract 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 XXIII – Termination of Coverage

This Contract may be terminated as follows:

- A. Automatic Termination of this Contract.** This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.
- B. Automatic Termination of Your Coverage.** Coverage under this Contract shall automatically terminate:
1. For Spouses in cases of divorce, the date of the divorce.
 2. For Children, the [12the end of the [month; year] in which] the Child turns [1326] years of age.
 3. For all other Dependents, the [12day; end of the month; year] in which the Dependent ceases to be eligible, except that We shall not terminate Your Dependent if Your Dependent becomes eligible for or enrolls in Medicare.

Eligibility or enrolment in Medicare is not a basis for termination under this Contract.

- C. Termination by You.** The Subscriber may terminate this Contract at any time by giving Us at least 30 days prior written notice.
- D. Termination by Us.** We may terminate this Contract with 30 days written notice as follows:
1. For non-payment of Premiums. Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
 - ♦ If the Subscriber fails to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last date Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.
 2. Fraud or Intentional Misrepresentation of Material Fact. If the Subscriber has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber from Us. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind this Contract if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to [14a year; the issuance of this Contract].

3. If the Subscriber no longer lives or resides in Our Service Area.
4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least five months prior written notice.
5. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide the Subscriber with at least 180 days prior written notice.

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

See the Conversion Right to a New Contract After Termination section of this Contract for Your right to conversion to another individual Contract.

Section XXIV – Extension of Benefits

When Your coverage under this Contract ends, benefits stop. But, if You are totally disabled on the date the Contract 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. If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled; or
- 12 months from the date this Contract terminated.

B. Limits on Extended Benefits. We will not pay extended benefits:

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

Section XXV - Right To New Contract After Termination

- A. Circumstances Giving Rise to Right to Conversion.** The Subscriber's Spouse and Children have the right to convert to a new Contract if their coverage under this Contract terminates under the circumstances described below.
1. **Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Contract 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.
 2. **Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Contract because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
 3. **On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Contract because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.
- 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 Your 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 Contracts offered by Us.

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 Contract 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 due under this Contract to any person, corporation, or other organization. You cannot assign any monies due under this Contract to any person, corporation, or other organization unless it is an assignment to Your Physician for a surprise bill for Covered Services provided on and after April 1, 2015. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract 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 Contract.** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.
4. **Choice of Law.** This Contract shall be governed by the laws of the State of New York.
5. **Clerical Error.** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, 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 Contract 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. **Entire Agreement.** This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.
9. **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.

10. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like 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.
11. **Identification Cards.** Identification ("ID) cards are issued by Us for identification purposes only. Possession of any identification card confers no right to services or benefits under this Contract. 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.
12. **Incontestability.** No statement by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.
13. **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.
14. **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.
15. **Material Accessibility.** We will give You, ID cards, Contracts, riders, and other necessary materials.
16. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Contract. 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 Contract.

- 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.
17. **Notice.** Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. 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: [2XXX].
18. **Premium Payment.** The initial premium is payable one month in advance by the Subscriber to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.
19. **Premium Refund.** We will give any refund of Premiums, if due, to the Subscriber.
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 Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by this Contract, or by the Subscriber upon 30 days' prior written notice to Us.
22. **Reinstatement After Default.** If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.
23. **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 Contract. 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 Contract. 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 Contract.

24. **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.
25. **Severability.** The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.
26. **Significant Change in Circumstances.** If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.
27. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Contract. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

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

between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

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

28. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Contract and nothing in this Contract 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 Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract or to bring an action or pursuit for the breach of any terms of this Contract.
29. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.
30. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact Us at the number on your ID card to access these services.
31. **Venue for Legal Action.** If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.
32. **Waiver.** The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
33. **Who May Change This Contract.** This Contract 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 Contract 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.
34. **Who Receives Payment under this Contract.** Payments under this Contract 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.

35. **Workers' Compensation Not Affected.** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
36. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, 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 Contract, 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 Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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

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

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

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

Section XIII - Other Covered Services

Hemophilia Factor Benefits

This Section supplements the coverage outlined in your Contract and provides the below additional benefits. These benefits are available only when provided by the specific participating Providers listed below:

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

We Cover Hemophilia Factor 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 benefit will be provided in lieu of receiving 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.

Hemophilia Factor dispensed by an HTC will be Covered under your Chemotherapy benefit. You will be responsible to pay the applicable Chemotherapy cost-share shown in the Schedule of Benefits.

2. Non-Emergent Home Health Care - Assisted Administration of Factor

In addition to the Home Health Care Benefits available under Your Contract, we will Cover non-emergent administration of Hemophilia 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 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 Hemophilia Factor in Your home count towards Your Home Health Care visit limit. The cost-share 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 benefit only provides Coverage for assisted administration of Factor. It does not Cover Factor that you self-administer or that is administered by a non-skilled caregiver.

3. Preauthorization

The benefits covered by 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 benefits 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 Contract apply to the benefits covered by this Section.

5. Controlling Policy

All of the terms, conditions, limitations, and exclusions of Your Contract shall also apply to this Section except where specifically changed by this Section.

STATEMENT OF VARIABILITY

- ¹ The officer signature will be added.
- ² The website address will be included.
- ³ The phone number will be included.
- ⁴ The hours for customer service will be included.
- ⁵ This language will be used with plans in which the individual Deductible applies to each person Covered under this Contract.
- ⁶ This language will be used with plans that require payment of the family deductible during each plan year for other than individual coverage.
- ⁷ The appropriate termination timeframe (end of month or end of year) will be included.
- ⁸ Dependents will either be covered to the age of 26 or the age of 29.
- ⁹ If coverage is only available when you are a permanent legal guardian this language will be included.
- ¹⁰ If a limit applies to Skilled Nursing this language will be included. If the benefit is unlimited this language will be removed.
- ¹¹ The therapeutic classes that are part of the designated pharmacy benefit will be included.
- ¹² Coverage will terminate on either the end of the month or the date on which eligibility is lost.
- ¹³ Dependents will either be covered to the age of 26 or the age of 29.
- ¹² Coverage will terminate on either the end of the month or the date on which eligibility is lost.
- ¹⁴ The appropriate language describing the retroactivity of the rescission provision will be included.

This is Your
HEALTH MAINTENANCE ORGANIZATION CONTRACT
Issued by
Oxford Health Plans (NY), Inc.

This is Your individual direct payment Contract for health maintenance organization coverage issued by Oxford Health Plans (NY), Inc. This Contract, together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this Contract, constitute the entire agreement between the Responsible Adult and Us.

You or the Responsible Adult have the right to return this Contract. Examine it carefully. If You or the Responsible Adult are not satisfied, You or the Responsible Adult may return this Contract to Us and ask Us to cancel it. Your or the Responsible Adult's request must be made in writing within ten (10) days from the date You or the Responsible Adult receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. Refer to the Termination of Coverage section of this Contract for the renewal provisions. Coverage under this Contract lasts until the end of the year in which You turn 21 years of age.

In-Network Benefits. This Contract only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers in Our Compass network. Care Covered under this Contract (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 Contract, 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 Contract. Except for care for an Emergency Condition described in the Emergency Services and Urgent Care section of this Contract, You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

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

[¹Officer Signature]

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Section I - Definitions

Defined terms will appear capitalized throughout this Contract.

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 Contract 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.

Child, Children: The Responsible Adult's Children, including any natural, adopted or step-children, newborn Children, or any other Children as described in the "Who is Covered" section of this Contract.

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.

Contract: This Contract issued by Oxford Health Plans (NY), Inc., including the Schedule of Benefits and any attached riders.

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 or arranged for You by Us under the terms and conditions of this Contract.

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
- As 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(1) 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.

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; 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 Contract.

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 rehabilitatory 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 Contract 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 [²XXX] or upon Your request to Us. The list will be revised from time to time by Us.

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

Plan Year: A calendar year ending on December 31 of each year.

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

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 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.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Contract 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.

Responsible Adult: The person who enters into this Contract with Us on behalf of his or her Child or Children.

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

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties: Bronx, Dutchess, 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.

Subscriber: The person to whom this Contract is issued. Subscriber refers to the Responsible Adult if the Member is under 18 years of age.

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 Plans (NY), Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

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

You, Your: The Member.

Section II - How Your Coverage Works

- A. **Your Coverage Under this Contract.** You or the Responsible Adult have purchased a HMO Contract from Us. This Contract is issued to cover the Responsible Adult's Children (referred to as You) who are under 21 years of age. We will provide the benefits described in this Contract to You. You or the Responsible Adult should keep this Contract 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 Contract 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 Contract; and
 - Received while Your Contract is in force.

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

- C. **Participating Providers.** To find out if a Provider is a Participating Provider:
- Check Your Provider directory, available at Your request;
 - Call the number on Your ID card; or
 - Visit our website at [²XXX].
- D. **The Role of Primary Care Physicians.** This Contract 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 HMO Compass Network. Each Member may select a different PCP. Children covered under this Contract 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 Contract 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 Contract 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 Contract for the services that require a Referral.

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

To see a Provider, call his or her office and tell the Provider that you are an Oxford Health Plans (NY), Inc. Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your 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 Contract 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 Contract 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.

See Section IX – Grievance, Utilization Review & External Appeals of this Contract 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 provided on or after April 1, 2015 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.

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.

I. **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

J. Important Telephone Numbers and Addresses.

- **CLAIMS**

- [³XXX-XXX-XXXX]

- *(Submit claim forms to this address.)

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

- [³XXX-XXX-XXXX]

- **MEDICAL EMERGENCIES AND URGENT CARE**

- [³XXX-XXX-XXXX]

- [³Monday - Friday 8:00 a.m. - 5:00 p.m.]

- [³Evenings, Weekends and Holidays]

- **CUSTOMER SERVICE**

- [³XXX-XXX-XXXX]

- *(Customer Service Representatives are available [⁴Monday – Friday 8:00 a.m. – 5:00 p.m.]

- **PREAUTHORIZATION**

- [³XXX-XXX-XXXX]

- **OUR WEBSITE**

- [²XXX]

Section III - Access to Care and Transitional Care

- A. Referral to a Non-Participating Provider.** Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, 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 only be responsible 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 Contract 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 Contract. 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 Contract 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

⁵A. **Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Contract. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.]

⁶A. **Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Contract for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Benefits section of this Contract for Covered in-network Services under this Contract during each Plan Year before We provide coverage for any person covered under this Contract. However, after Deductible payments for persons covered under this Contract collectively total the family Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Deductible will be required for any person covered under this Contract for that Plan Year.]

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

- B. **Copayments.** Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.
- C. **Coinsurance.** Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Contract.
- 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 Contract, 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 Contract. 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 Contract

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 Contract, 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 Contract, 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.

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

Section V - Who is Covered

- A. Who is Covered Under this Contract.** This Contract is issued to cover the Responsible Adult's Children (known as You) who are under 21 years of age. Coverage lasts until the end of the year in which You turn 21 years of age.
- B. Children Covered Under This Contract.** Children covered under this Contract include natural Children, legally adopted Children, step Children, foster Children and Children for whom the Responsible Adult is the proposed adoptive parent without regard to financial dependence, residency with the Responsible Adult, 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 also includes Children for whom the Responsible Adult is a [7permanent] legal guardian if the Children are chiefly dependent upon the Responsible Adult for support and the Responsible Adult has been appointed the legal guardian by a court order. Grandchildren of the Responsible Adult are not covered.

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 Members in relation to eligibility for coverage under this Contract at any time.

- D. Open Enrollment.** For Plan Years beginning on or after January 1, 2015, You can enroll under this Contract during an open enrollment period that runs from November 15, 2014, through February 15, 2015. If We receive Your selection on or before December 15, 2014, Your coverage will begin on January 1, 2015, as long as the applicable premium payment is received by then. If We receive Your selection between the dates of December 16, 2014, through January 15, 2015, Your coverage will begin on February 1, 2015, as long as the applicable premium payment is received by then. If We receive Your selection between the dates of January 16, 2015, through February 15, 2015, Your coverage will begin on March 1, 2015, as long as the applicable premium payment is received by then.

For Plan Years beginning on or after January 1, 2016, You can enroll under this Contract during an annual open enrollment period that runs from October 15 through December 7. If We receive Your selection between these dates, Your coverage will begin on January 1 of the following year, as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

- E. Special Enrollment Periods.** Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days of the occurrence of one of the following events:

1. You lose minimum essential coverage;

2. Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the NYSOH.;
3. You adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract;
4. You move and become eligible for new health plans;
5. The Responsible Adult gains a Child through birth, adoption or placement for adoption;
6. You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
7. You exhausted Your COBRA or continuation coverage.

We must receive notice and premium payment within 60 days of one of these events.

If You enroll because You lost minimum essential coverage, Your coverage will begin on the first day of the month following Your loss of coverage.

If the Responsible Adult has a newborn or adopted newborn Child and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if the Responsible Adult takes physical custody of the infant as soon as the infant is released from the Hospital after birth and the Responsible Adult files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. The Responsible Adult or You must also pay any applicable additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise coverage begins on the date on which We receive notice and the premium payment.

In all other cases, the effective date of Your coverage will depend on when We receive Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection 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, as long as Your applicable premium payment is received by then.

Section VI – Preventive Care

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

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on your ID card or visit Our website at [²XXX] 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.
- 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 [²XXX], 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.

- 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.
- 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 [2XXX], 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.
- E. Mammograms.** We Cover mammograms for the screening of breast cancer as follows:
- One baseline screening mammogram for women age 35 through 39; and
 - One 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.

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 and Reproductive Health Services.** We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of the Contract, 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.

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 the Contract. 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;
- 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.

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.

Section VII - Pre-Hospital Emergency Medical Services and Ambulance Services

Please refer to the Schedule of Benefits section of this Contract 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 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 of the following is met:
 - ♦ The point of pick-up is inaccessible by land vehicle; or
 - ♦ Great distances or other obstacles (for example, 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 Contract 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 in this Contract and 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.

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

- B. Urgent Care.** Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as

to require Emergency Department Care. **Urgent Care is Covered in or out of Our Service Area.**

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

I. Home Health Care. We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;

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

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is considered one 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 :

- ◆ 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);
- ◆ Sex change procedures;
- ◆ 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 into the muscles 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 for one procedure per Member, per Plan Year.
- 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 Contract for Coverage of inpatient maternity care.
- We Cover the cost of renting one breast pump per pregnancy for the duration of breast feeding.
- O. Medications for Use in the Office.** We Cover medications and injectables (excluding self-injectables used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of the Contract.
- 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 Contract 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 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.

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 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 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 Contract 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, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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, laptops, 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 an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "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.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

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 Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Contract.
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 Contract.
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 the Contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Contract for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. Any Copayment, Deductible or Coinsurance that applies to office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Contract 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 Jump
- ◆ 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 will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

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

2. Braces. We Cover braces 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 or both ears once every three (3) 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 hearing aid per ear during the entire period of time that You are enrolled under this Contract. 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 months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover : funeral arrangements; pastoral, financial, or legal counseling; 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 Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. 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 of this Contract 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 Contract and are only Covered under the Pediatric Vision Care section of this Contract.

We do not Cover orthotics.

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

Coverage is for standard equipment only.

- ♦ **External Prosthetic Devices for Adults.** For adults, We Cover the cost of one prosthetic device, per limb, per lifetime. We do not Cover the cost of repair or replacement.
 - ♦ **External Prosthetic Devices for Children.** For children, We Cover the cost of one prosthetic device, per limb, per lifetime. We Cover the cost of replacement for children but only if the previous device has been outgrown. We do not Cover the cost of repairs.
- 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 Contract 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 Contract 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 Contract.
- 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 Contract and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Contract 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 Plan 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 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 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 Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. [\[⁶We Cover up to 200 days, per Plan Year, for non-custodial care.\]](#)

- 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 Contract until the External Appeal Agent renders a decision in Our favor.

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

1. We will reimburse a rate that has been negotiated between Us and the Provider.

2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care service 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 Contract 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 Contract. 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 Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the 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 alcoholism, substance use and dependency. 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 alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1) and to services provided in such Facilities in accordance with 14 NYCRR Parts 817 and 819; 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 alcoholism, substance use and dependency, 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 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 and/or dependency; and 2) is covered under the same family Contract that covers the person receiving, or in need of, treatment for substance use and/or dependency. 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 Contract for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Outpatient 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 Contract.
- 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.
- Prescription Drugs for smoking cessation.
- 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 [²XXX]. You may inquire if a specific drug is Covered under this Contract 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 $\frac{3}{4}$ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one 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 XIV – Schedule of Benefits of this Contract.

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 Contract when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy.

You have a three 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 [²XXX] 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:

- ◆ [9]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 [\[²XXX\]](#) 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 [\[²XXX\]](#) 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 Prescription 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 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 [²XXX] or by calling the number on Your ID card.

7. **When a Brand-Name Drug Becomes Available as a Generic.** When a Brand-Name Drug becomes available as a Generic, 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 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 Contract.
8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You may request a Formulary exception for a clinically-appropriate Prescription Drug. Visit Our website at [²XXX] or call the number on your ID card to find out more about this process.
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 Cost-Sharing amount for up to a 30-day supply.

Benefits will be provided for drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one Cost-Share amount for a 30-day supply up to a maximum of two and a half Cost-Share amounts for a 90-day supply.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at [²XXX] or by calling the telephone number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Contract.
9. **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 in Section XIV – Schedule of Benefits of this Contract 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 Contract.
10. **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 [²XXX] or by calling the telephone number on Your ID card.

D. Medical Management. This Contract 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 [²XXX] 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 of 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 Contract. 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 type 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 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 Contract.
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 Contract.
7. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Contract. 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 Contract.

13. 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, 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 Contract).

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 Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at [2XXX] 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. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
6. **Participating Pharmacy:** A pharmacy that has:
 - ◆ Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
 - ◆ Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
 - ◆ Been designated by Us as a Participating Pharmacy.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 Contract 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-month period.

In order to obtain reimbursement, at the end of the six-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 Spouse or the actual cost of the membership per six-month period.

Section XV - Pediatric Vision Care

Please refer to the Schedule of Benefits section of this Contract 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 up to age 19.
- B. Vision Examinations.** We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
- Case history;
 - External examination of the eye or internal examination of the eye;
 - Ophthalmoscopic exam;
 - Determination of refractive status;
 - Binocular distance;
 - Tonometry tests for glaucoma;
 - Gross visual fields and color vision testing; and
 - Summary findings and recommendation for corrective lenses.
- C. Prescribed Lenses & Frames.** We Cover standard prescription lenses or contact lenses for Members up to age 19, one (1) time in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation.

We do not Cover prescribed lenses and frames for Members over the age of 18.

Section XVI - Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Contract 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 up to age 19:

- 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 thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (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 Contract.
- 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

No coverage is available under this Contract 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 Contract. 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 Contract 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 except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care section of this Contract.
- 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 Contract, 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 the Contract for non-investigational

treatments. See the Utilization Review and External Appeal sections of this Contract 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 unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.
- J. Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Contract.
- 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).
- 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 Contract 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 Contract.
- S. War.** We will 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 Contract. 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.
- 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 [²XXX]. Completed claim forms should be sent to the address in the How Your Coverage Works of this Contract or on Your ID card. Effective on the date of issuance or renewal of this Contract on or after April 1, 2015, You may also submit a claim to Us electronically by sending it to the e-mail on Your ID card or visiting Our website at [²XXX].
- 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 days 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 section of this Contract.
- For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Contract.
- 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 time period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.

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

Section IX – Grievance Procedures

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

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

We keep all requests and discussions confidential and We'll 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 a service.)

In writing, within 30 calendar days of receipt of Your Grievance.

- D. Assistance.** If You remain dissatisfied with Our Grievance determination or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:

New York State Department of Health

Corning Tower

Empire State Plaza

Albany, NY 12237

www.health.ny.gov

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

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: 1-888-614-5400

Or e-mail cha@cssny.org

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 Provider who typically manages Your medical condition or disease or provides the health care service under review. 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 [2XXX].

B. Preauthorization Reviews.

1. 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 time period.

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.

C. Concurrent Reviews.

1. 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 time period.

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

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

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 before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. 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.** Beginning April 1, 2015, You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat your condition:
 - ◆ That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
 - ◆ Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

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

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.

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

Community Health Advocates

105 East 22nd Street

New York, NY. 10010

Or call toll free: 1-888-614-5400

Or e-mail cha@cssny.org

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 does not meet Our requirements for Medical Necessity (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 requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Contract; 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 does not meet Our requirements for Medical Necessity, 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 requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:
- Standard health services are ineffective or medically inappropriate; **or**
 - There does not exist a more beneficial standard service or procedure covered by Us; **or**

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

In addition, Your attending Physician must have recommended one 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 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.

You do not have a right to an external appeal for a denial of a Referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by You.

- E. Your Right to Appeal an Out-of-Network Referral Denial.** Beginning on April 1, 2015, if We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two 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. The External Appeal Process.** You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

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

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

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your

attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment We will provide coverage subject to the other terms and conditions of this Contract. 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 Contract 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 XXIII – Termination of Coverage

This Contract may be terminated as follows:

- A. Automatic Termination of this Contract.** This Contract will automatically terminate upon Your death. If this Contract covers more than one Child, then the Contract will remain in force for the remaining Children.
- B. Automatic Termination of Your Coverage.** Coverage under this Contract shall automatically terminate at the end of the year in which You turn 21 years of age.

Eligibility or enrolment in Medicare is not a basis for termination under this Contract.

- C. Termination by You.** You or the Responsible Adult may terminate this Contract at any time by giving Us at least 30 days prior written notice.
- D. Termination by Us.** We may terminate this Contract with 30 days written notice as follows:

1. For non-payment of Premiums. Premiums are to be paid by You or the Responsible Adult to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
 - ♦ If You or the Responsible Adult fail to pay the required Premium within a 30-day grace period, this Contract will terminate retroactively back to the last date Premiums were paid. You or the Responsible Adult will be responsible for paying any claims submitted during the grace period if this Contract terminates.
2. Fraud or Intentional Misrepresentation of Material Fact. If You or the Responsible Adult have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon a written notice to You or the Responsible Adult from Us. However, if You or the Responsible Adult makes an intentional misrepresentation of material fact in writing on Your enrollment application We will rescind this Contract if the facts misrepresented would have led Us to refuse to issue this Contract and Your application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to ^[10][a year; the issuance of this Contract](#).
3. If You or the Responsible Adult no longer live or reside in Our Service Area.
4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least five months prior written notice.

5. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide the Subscriber with at least 180 days prior written notice.

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

See the Conversion Right to a New Contract After Termination section of this Contract for Your right to conversion to another individual Contract.

Section XXIV – Extension of Benefits

When Your coverage under this Contract ends, benefits stop. But, if You are totally disabled on the date the Contract 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. If You are totally disabled on the date Your coverage under this Contract terminates, We will continue to pay for Your care under this Contract during an uninterrupted period of total disability until the first of the following:

- The date You are no longer totally disabled; or
- 12 months from the date this Contract terminated.

B. Limits on Extended Benefits. We will not pay extended benefits:

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

Section XXV - Right To New Contract After Termination

- A. Circumstances Giving Rise to Right to Conversion.** You have the right to convert to a new Contract if Your coverage under this Contract terminates under the Termination of Coverage section of this Contract because you turn 21 years of age. You are 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 Your 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 Contracts offered by Us.

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 Contract 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 due under this Contract to any person, corporation, or other organization. You cannot assign any monies due under this Contract to any person, corporation, or other organization unless it is an assignment to Your Physician for a surprise bill for Covered Services provided on and after April 1, 2015. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract 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 Contract.** We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.
4. **Choice of Law.** This Contract shall be governed by the laws of the State of New York.
5. **Clerical Error.** Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, 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 Contract 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. **Entire Agreement.** This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.
9. **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.

10. **Furnishing Information and Audit.** All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons like 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.
11. **Identification Cards.** Identification ("ID) cards are issued by Us for identification purposes only. Possession of any identification card confers no right to services or benefits under this Contract. 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.
12. **Incontestability.** No statement by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.
13. **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.
14. **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.
15. **Material Accessibility.** We will give You, ID cards, Contracts, riders, and other necessary materials.
16. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Contract. 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 Contract.

- 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.
17. **Notice.** Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. 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: [11XXX].
18. **Premium Payment.** The initial premium is payable one month in advance by the Subscriber to Us at Our office. The first month's premium is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter.
19. **Premium Refund.** We will give any refund of Premiums, if due, to the Subscriber.
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 Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by this Contract, or by the Subscriber upon 30 days' prior written notice to Us.
22. **Reinstatement After Default.** If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.
23. **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 Contract. 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 Contract. 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 Contract.

24. **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.
25. **Severability.** The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.
26. **Significant Change in Circumstances.** If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.
27. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Contract. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

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

between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

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

28. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Contract and nothing in this Contract 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 Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract or to bring an action or pursuit for the breach of any terms of this Contract.
29. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within 2 years from the date the claim was required to be filed.
30. **Translation Services.** Translation services are available under this Contract for non-English speaking Members. Please contact Us at the number on your ID card to access these services.
31. **Venue for Legal Action.** If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.
32. **Waiver.** The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
33. **Who May Change This Contract.** This Contract 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 Contract 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.
34. **Who Receives Payment under this Contract.** Payments under this Contract 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.

35. **Workers' Compensation Not Affected.** The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
36. **Your Medical Records and Reports.** In order to provide Your coverage under this Contract, 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 Contract, 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 Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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

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

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

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

Section XIII - Other Covered Services

Hemophilia Factor Benefits

This Section supplements the coverage outlined in your Contract and provides the below additional benefits. These benefits are available only when provided by the specific participating Providers listed below:

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

We Cover Hemophilia Factor 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 benefit will be provided in lieu of receiving 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.

Hemophilia Factor dispensed by an HTC will be Covered under your Chemotherapy benefit. You will be responsible to pay the applicable Chemotherapy cost-share shown in the Schedule of Benefits.

2. Non-Emergent Home Health Care - Assisted Administration of Factor

In addition to the Home Health Care Benefits available under Your Contract, we will Cover non-emergent administration of Hemophilia 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 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 Hemophilia Factor in Your home count towards Your Home Health Care visit limit. The cost-share 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 benefit only provides Coverage for assisted administration of Factor. It does not Cover Factor that you self-administer or that is administered by a non-skilled caregiver.

3. Preauthorization

The benefits covered by 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 benefits 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 Contract apply to the benefits covered by this Section.

5. Controlling Policy

All of the terms, conditions, limitations, and exclusions of Your Contract shall also apply to this Section except where specifically changed by this Section.

STATEMENT OF VARIABILITY

- ¹ The officer signature will be added.
- ² The website address will be included.
- ³ The phone number will be included.
- ⁴ The hours for customer service will be included.
- ⁵ This language will be used with plans in which the individual Deductible applies to each person Covered under this Contract.
- ⁶ This language will be used with plans that require payment of the family deductible during each plan year for other than individual coverage.
- ⁷ If coverage is only available when you are a permanent legal guardian this language will be included.
- ⁸ If a limit applies to Skilled Nursing this language will be included. If the benefit is unlimited this language will be removed.
- ⁹ The therapeutic classes that are part of the designated pharmacy benefit will be included.
- ¹⁰ The appropriate language describing the retroactivity of the rescission provision will be included.
- ¹¹ The address for notice will be included.

Out-of-Network Benefits Rider

This rider amends Your Contract to provide benefits for Covered Services that are received from Non-Participating Providers and have not been approved by Us to be covered on an in-network basis. These benefits are referred to as “out-of-network benefits” and are subject to greater Copayment, Deductible and Coinsurance amounts than the benefits available if You obtain the same services from Participating Providers.

- A. **Out-Of-Network Benefits.** Benefits under this rider are only available for Medically Necessary services provided by Non-Participating Providers [¹outside Our Service Area] which would have been Covered under Your Contract if they had been provided by a Participating Provider. All services must be furnished by Providers appropriately licensed to provide the particular service being rendered. See the Schedule of Benefits section of this Contract for a list of the services covered out-of-network. Some services are only Covered when You go to a Participating Provider.
- B. **Day and Limit Visitations.** In any case where benefits of the Contract are limited to a certain number of days or visits, such limits shall apply in the aggregate to services provided pursuant to the Contract and this rider. Any days or visits covered pursuant to this rider will reduce the number of days or visits available under the Contract and vice versa.
- C. **Out-of-Network Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered out-of-network Services. See the Schedule of Benefits section of this Contract for the services that require Preauthorization.
- D. **Preauthorization Procedure.** If You seek coverage for services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

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

- E. **Failure to Seek Preauthorization.** If You fail to seek Our Preauthorization for benefits subject to this section, We will pay an amount \$500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.
- F. **Out-of-Network Deductible.** This Contract has a separate Out-of-Network Deductible in the Schedule of Benefits section of this Contract that You must pay for Covered out-of-network Services during each Plan Year before We provide coverage for out-of-network services. If You have other than Individual coverage, the individual Out-of-Network Deductible applies to each person covered under this Contract. However, after Out-of-Network Deductible payments for persons covered under this Contract collectively total the family Out-of-Network Deductible amount in the Schedule of Benefits section of this Contract in a Plan Year, no further Out-of-Network Deductible will be required for any person covered under this Contract for that Plan Year. 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 Out-of-Network Deductible.** The Out-of-Network Deductible runs from January 1 to December 31 of each calendar year.
- G. **Out-of-Network Out-of-Pocket Limit.** This Contract has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Contract for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If you have other than individual coverage, the individual Out-of-Network Out-of-Pocket Limit applies to each person covered under this Contract. Once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person. If other than Individual coverage applies, when persons in the same family covered under this Contract have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. **Any charges of a Non-Participating Provider that are in excess of the**

Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.

Cost-Sharing for in-network services does not apply toward your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in this rider does not apply toward Your Out-of-Network Out-of-Pocket Limit. The Out-of-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

H. Your Additional Payments for Out-of-Network Benefits

When You receive Covered services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Contract, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

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

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

- 1. Facilities.** For Facilities, the Allowed Amount will be 140% of the Medicare amount.

If there is no amount as described above, the Allowed Amount will be 50% of the Facility's charge.

- 2. For All Other Providers.** For all other Providers, the Allowed Amount will be 140% of the Medicare amount.

If there is no amount as described above, We use a gap methodology established by a *OptumInsight* and/or a third party vendor that uses a relative

value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). [We and OptumInsight are related companies through common ownership by UnitedHealth Group.](#) Refer to our website for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

If there is no amount as described above, the Allowed Amount will be 50% of the Provider's charge.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge.

Contact Us at the number on Your ID card or visit our website for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers. Medicare based rates referenced in and applied under this Section shall be updated no less than annually.

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

- J. **Filing a Claim For Out of Network Benefits.** A claim must be filed with Us by You or the out-of-network Provider. Claims forms can be obtained from Us by calling the number on your ID card or by visiting our website.
- K. **Exclusions.** Except as expressly modified by this rider, all of the exclusions of the Contract apply to the benefits covered by this rider.
- L. **Controlling Contract.** All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

Statement of Variability

¹ If services for non-participating providers are only covered outside the service area this language will be included.

SECTION XXVII - Liberty HMO Schedule of Benefits

Silver Plan

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible	
Individual	\$2,000
Family	\$4,000
Out-of-Pocket Limit	
Individual	\$5,500
Family	\$11,000

Office Visits	Participating Provider Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$30 Copayment after Deductible	See benefit for description
Medications Administered in Office	\$30 Copayment after Deductible	
Specialist Office Visits (or Home Visits)	\$50 Copayment after Deductible	See benefit for description
Medications Administered in Office	\$50 Copayment after Deductible	
<i>[Preauthorization; Referral Required]</i>		

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Preventive Care		
Well Child Visits and Immunizations*	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	
Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
Mammography Screenings*	Covered in full	
Sterilization Procedures for Women*	Covered in full	
Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
Bone Density Testing*	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
USPSTF and HRSA. <i>[Referral Required]</i>	Procedures & Diagnostic Testing)	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	\$150 Copayment after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$150 Copayment after Deductible	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	\$70 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology		See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Facility or Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$50 Copayment after Deductible \$50 Copayment after Deductible	
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible \$50 Copayment after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[Preauthorization; Referral Required]</i>	\$100 Copayment after Deductible	See benefit for description
Anesthesia Services (all settings) <i>[Preauthorization; Referral Required]</i>	Covered in full	See benefit for description
Autologous Blood Banking <i>[Preauthorization; Referral Required]</i>	\$50 Copayment after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office	\$30 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description
Chiropractic Services <i>[Preauthorization; Referral Required]</i>	\$50 Copayment after Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital	\$30 Copayment after Deductible \$50 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Services <i>[Preauthorization; Referral Required]</i>	\$50 Copayment after Deductible	
Dialysis Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description Dialysis performed by Non- Participating Providers is limited to 10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	40 visits per Plan Year

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services <i>[Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible \$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description Home infusion counts towards Home Health Care visit limits
Inpatient Medical Visits <i>[Preauthorization; Referral Required]</i>	Covered in Full	See benefit for description
Laboratory Procedures Performed in a PCP Office	\$30 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$50 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p>	
<p>Maternity & Newborn Care</p> <p>Prenatal Care</p> <p>Inpatient Hospital Services and Birthing Center</p> <p>Physician and Midwife Services for Delivery</p> <p>Breast Pump</p> <p>Postnatal Care</p> <p><i>[Preauthorization Required [for Inpatient]</i></p>	<p>Covered in Full</p> <p>\$1,500 Copayment per admission after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>Covered in Full</p> <p>\$50 Copayment after Deductible</p>	<p>See benefit for description</p> <p>1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Services; Breast Pump]</i>		
Outpatient Hospital Surgery Facility Charge <i>[Preauthorization; Referral Required]</i>	\$100 Copayment after Deductible	See benefit for description
Preadmission Testing <i>[Preauthorization; Referral Required]</i>	\$0 Copayment after Deductible	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment after Deductible	See benefit for description
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services	\$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	60 visits per Plan 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 <i>[Preauthorization; Referral Required]</i>	\$50 Copayment after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery	\$100 Copayment after Deductible \$100 Copayment after Deductible \$100 Copayment after Deductible \$50 Copayment after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[Preauthorization; Referral Required [for Insulin Pump]]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible	See benefit for description

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
Durable Medical Equipment & Braces <i>[Preauthorization; Referral Required]</i>	30% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[Preauthorization; Referral Required]</i>	30% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[Preauthorization; Referral Required]</i>	\$1,500 Copayment per admission after Deductible \$30 Copayment after Deductible	210 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies <i>[Preauthorization; Referral Required]</i>	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices External	30% Coinsurance after Deductible	One prosthetic device, per limb, per

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Internal</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>30% Coinsurance after Deductible</p>	<p>lifetime</p> <p>Unlimited</p> <p>See benefit for description</p>

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$1,500 Copayment per admission after Deductible</p>	<p>See benefit for description</p>
<p>Observation Stay</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$150 Copayment after Deductible</p>	<p>See benefit for description</p>

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[Preauthorization; Referral Required]</i>	\$1,500 Copayment per admission after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[Preauthorization; Referral Required]</i>	\$1,500 Copayment per admission after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$1,500 Copayment per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive	\$30 Copayment after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Program Services) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>		
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$1,500 Copayment per admission after Deductible	See benefit for description
Outpatient Substance Use Services <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply		See benefit for description

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 1 Tier 2 Tier 3	\$10 Copayment not subject to Deductible \$35 Copayment not subject to Deductible \$70 Copayment not subject to Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$25 Copayment not subject to Deductible \$87.50 Copayment not subject to Deductible \$175 Copayment not subject to Deductible	See benefit for description

Wellness Benefits	Participating Provider Member Responsibility for Cost-Sharing	Limits
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Gym Reimbursement	Not Applicable	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse
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Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care	\$30 Copayment after Deductible	One dental exam and cleaning per

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[Orthodontics Require Preauthorization; Referral]</i>	\$30 Copayment after Deductible \$30 Copayment after Deductible \$30 Copayment after Deductible	6-month period
Pediatric Vision Care Exams Lenses & Frames Contact Lenses <i>[Contact Lenses Require Preauthorization; Referral]</i>	\$30 Copayment after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12-month period

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.

Statement of Variability

The language indicating which benefits require preauthorization or referral has been bracketed. The language will be included only for those services that specifically require the preauthorization or referral.

SECTION XXVII - Liberty HMO Schedule of Benefits

Gold Plan

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible	
Individual	\$600
Family	\$1,200
Out-of-Pocket Limit	
Individual	\$4,000
Family	\$8,000

Office Visits	Participating Provider Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$25 Copayment after Deductible	See benefit for description
Medications Administered in Office	\$25 Copayment after Deductible	
Specialist Office Visits (or Home Visits)	\$40 Copayment after Deductible	See benefit for description
Medications Administered in Office	\$40 Copayment after Deductible	
<i>[Preauthorization; Referral Required]</i>		

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Preventive Care		
Well Child Visits and Immunizations*	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	
Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
Mammography Screenings*	Covered in full	
Sterilization Procedures for Women*	Covered in full	
Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
Bone Density Testing*	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
USPSTF and HRSA. <i>[Referral Required]</i>	Procedures & Diagnostic Testing)	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	\$150 Copayment after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$150 Copayment after Deductible	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	\$60 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology		See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Facility or Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible \$40 Copayment after Deductible	
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible \$40 Copayment after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[Preauthorization; Referral Required]</i>	\$100 Copayment after Deductible	See benefit for description
Anesthesia Services (all settings) <i>[Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office	\$25 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible	See benefit for description
Chiropractic Services <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital	\$25 Copayment after Deductible \$40 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Services <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	
Dialysis Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	60 visits per Plan Year for PT/OT/ST combined
Home Health Care <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible	40 visits per Plan Year

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services <i>[Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible	See benefit for description Home infusion counts towards Home Health Care visit limits
Inpatient Medical Visits <i>[Preauthorization; Referral Required]</i>	Covered in Full	See benefit for description
Laboratory Procedures Performed in a PCP Office	\$25 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	
<p>Maternity & Newborn Care</p> <p>Prenatal Care</p> <p>Inpatient Hospital Services and Birthing Center</p> <p>Physician and Midwife Services for Delivery</p> <p>Breast Pump</p> <p>Postnatal Care</p> <p><i>[Preauthorization Required [for Inpatient]</i></p>	<p>Covered in Full</p> <p>\$1,000 Copayment per admission after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>Covered in Full</p> <p>\$40 Copayment after Deductible</p>	<p>See benefit for description</p> <p>1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Services; Breast Pump]</i>		
Outpatient Hospital Surgery Facility Charge <i>[Preauthorization; Referral Required]</i>	\$100 Copayment after Deductible	See benefit for description
Preadmission Testing <i>[Preauthorization; Referral Required]</i>	\$0 Copayment after Deductible	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible \$40 Copayment after Deductible \$40 Copayment after Deductible	See benefit for description
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services	\$25 Copayment after Deductible \$25 Copayment after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$30 Copayment after Deductible	60 visits per Plan 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 <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center	\$100 Copayment after Deductible \$100 Copayment after Deductible \$100 Copayment after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Office Surgery <i>[Preauthorization; Referral Required]</i>	\$40 Copayment after Deductible	

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[Preauthorization; Referral Required [for</i>	\$25 Copayment after Deductible \$25 Copayment after Deductible	See benefit for description

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Insulin Pump]]</i>		
Durable Medical Equipment & Braces <i>[Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[Preauthorization; Referral Required]</i>	\$1,000 Copayment per admission after Deductible \$25 Copayment after Deductible	210 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies <i>[Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	See benefit for description
Prosthetic Devices		

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
External	20% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime
Internal <i>[Preauthorization; Referral Required]</i>	20% Coinsurance after Deductible	Unlimited See benefit for description

Inpatient Services & Facilities	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) <i>[Preauthorization; Referral Required]</i>	\$1,000 Copayment per admission after Deductible	See benefit for description
Observation Stay <i>[Preauthorization; Referral Required]</i>	\$150 Copayment after Deductible	See benefit for description

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[Preauthorization; Referral Required]</i>	\$1,000 Copayment per admission after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[Preauthorization; Referral Required]</i>	\$1,000 Copayment per admission after Deductible	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$1,000 Copayment per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive	\$25 Copayment after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Program Services) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>		
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$1,000 Copayment per admission after Deductible	See benefit for description
Outpatient Substance Use Services <i>[Preauthorization; Referral Required]</i>	\$25 Copayment after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply		See benefit for description

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 1 Tier 2 Tier 3	\$10 Copayment not subject to Deductible \$35 Copayment not subject to Deductible \$70 Copayment not subject to Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$25 Copayment not subject to Deductible \$87.50 Copayment not subject to Deductible \$175 Copayment not subject to Deductible	See benefit for description

Wellness Benefits	Participating Provider Member Responsibility for Cost-Sharing	Limits
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Gym Reimbursement	Not Applicable	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse
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Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care	\$25 Copayment after Deductible	One dental exam and cleaning per

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[Orthodontics Require Preauthorization; Referral]</i>	\$25 Copayment after Deductible \$25 Copayment after Deductible \$25 Copayment after Deductible	6-month period
Pediatric Vision Care Exams Lenses & Frames Contact Lenses <i>[Contact Lenses Require Preauthorization; Referral]</i>	\$25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12-month period

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.

Statement of Variability

The language indicating which benefits require preauthorization or referral has been bracketed. The language will be included only for those services that specifically require the preauthorization or referral.

SECTION XXVII - Liberty HMO Schedule of Benefits

Platinum Plan

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible Individual Family	None None
Out-of-Pocket Limit Individual Family	\$2,000 \$4,000

Office Visits	Participating Provider Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment	See benefit for description
Medications Administered in Office	\$15 Copayment	
Specialist Office Visits (or Home Visits)	\$35 Copayment	See benefit for description
Medications Administered in Office	\$35 Copayment	
<i>[Preauthorization; Referral Required]</i>		

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Preventive Care		
Well Child Visits and Immunizations*	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	
Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
Mammography Screenings*	Covered in full	
Sterilization Procedures for Women*	Covered in full	
Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
Bone Density Testing*	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
USPSTF and HRSA. <i>[Referral Required]</i>	Procedures & Diagnostic Testing)	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$100 Copayment	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	\$55 Copayment	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology		See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Facility or Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$35 Copayment \$35 Copayment	
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$35 Copayment	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	See benefit for description
Anesthesia Services (all settings) <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	See benefit for description
Autologous Blood Banking <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office	\$15 Copayment	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$15 Copayment \$15 Copayment	See benefit for description
Chiropractic Services <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital	\$15 Copayment \$35 Copayment	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Services <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	
Dialysis Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$15 Copayment \$15 Copayment	See benefit for description Dialysis performed by Non- Participating Providers is limited to 10 visits per Plan Year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$25 Copayment	60 visits per Plan Year for PT/OT/ST combined
Home Health Care <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	40 visits per Plan Year

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services <i>[Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	See benefit for description Home infusion counts towards Home Health Care visit limits
Inpatient Medical Visits <i>[Preauthorization; Referral Required]</i>	Covered in Full	See benefit for description
Laboratory Procedures Performed in a PCP Office	\$15 Copayment	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$35 Copayment</p> <p>\$35 Copayment</p>	
<p>Maternity & Newborn Care</p> <p>Prenatal Care</p> <p>Inpatient Hospital Services and Birthing Center</p> <p>Physician and Midwife Services for Delivery</p> <p>Breast Pump</p> <p>Postnatal Care</p> <p><i>[Preauthorization Required [for Inpatient]</i></p>	<p>Covered in Full</p> <p>\$500 Copayment per admission</p> <p>\$100 Copayment</p> <p>Covered in Full</p> <p>\$35 Copayment</p>	<p>See benefit for description</p> <p>1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Services; Breast Pump]</i>		
Outpatient Hospital Surgery Facility Charge <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	See benefit for description
Preadmission Testing <i>[Preauthorization; Referral Required]</i>	\$0 Copayment	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$35 Copayment \$35 Copayment	See benefit for description
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services	\$15 Copayment \$15 Copayment	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	\$25 Copayment	60 visits Plan 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 <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery	 \$100 Copayment \$100 Copayment \$100 Copayment \$35 Copayment	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[Preauthorization; Referral Required [for Insulin Pump]]</i>	\$15 Copayment \$15 Copayment	See benefit for description

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
Durable Medical Equipment & Braces <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	See benefit for description
External Hearing Aids <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	Single purchase once Every 3 years
Cochlear Implants <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission \$15 Copayment	210 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	See benefit for description
Prosthetic Devices External	10% Coinsurance	One prosthetic device, per limb, per lifetime

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
Internal <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	Unlimited See benefit for description

Inpatient Services & Facilities	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) <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission	See benefit for description
Observation Stay <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$500 Copayment per admission	200 days per Plan Year

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>		
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission	60 days per Plan Year for PT/OT/ST combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$500 Copayment per admission	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[Preauthorization; Referral Required. However</i>	\$15 Copayment	See benefit for description

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Preauthorization is not Required for Emergency Admissions.]</i>		
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$500 Copayment per admission	See benefit for description
Outpatient Substance Use Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply Tier 1 Tier 2	\$10 Copayment \$30 Copayment	See benefit for description

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 3	\$60 Copayment	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$25 Copayment \$75 Copayment \$150 Copayment	See benefit for description

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

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics)	\$15 Copayment \$15 Copayment \$15 Copayment	One dental exam and cleaning per 6-month period

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Orthodontics <i>[Orthodontics Require Preauthorization; Referral]</i>	\$15 Copayment	
Pediatric Vision Care Exams Lenses & Frames Contact Lenses <i>[Contact Lenses Require Preauthorization; Referral]</i>	\$15 Copayment 10% Coinsurance 10% Coinsurance	One exam per 12-month period; One prescribed lenses and frames in a 12-month period

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.

Statement of Variability

The language indicating which benefits require preauthorization or referral has been bracketed. The language will be included only for those services that specifically require the preauthorization or referral.

SECTION XXVII - Liberty HMO Schedule of Benefits

Bronze Plan

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing
Deductible	
Individual	\$3,000
Family	\$6,000
Out-of-Pocket Limit	
Individual	\$6,350
Family	\$12,700

Office Visits	Participating Provider Member Responsibility for Cost- Sharing	Limits
Primary Care Office Visits (or Home Visits)	50% Coinsurance after Deductible	See benefit for description
Medications Administered in Office	50% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits)	50% Coinsurance after Deductible	See benefit for description
Medications Administered in Office	50% Coinsurance after Deductible	
<i>[Preauthorization; Referral Required]</i>		

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
Preventive Care		
Well Child Visits and Immunizations*	Covered in full	See benefit for description
Adult Annual Physical Examinations*	Covered in full	
Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
Mammography Screenings*	Covered in full	
Sterilization Procedures for Women*	Covered in full	
Vasectomy	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
Bone Density Testing*	Covered in full	
Screening for Prostate Cancer	Covered in full	
All other preventive services required by USPSTF and HRSA.	Covered in full	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Limits
USPSTF and HRSA. <i>[Referral Required]</i>	Procedures & Diagnostic Testing)	

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	50% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	50% Coinsurance after Deductible	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of-Network Urgent Care; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services Performed in a Freestanding Radiology		See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Facility or Office Setting Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible	
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office	50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed as Outpatient Hospital Services</p> <p>Performed as Inpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	
<p>Chemotherapy</p> <p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	See benefit for description
<p>Chiropractic Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	50% Coinsurance after Deductible	See benefit for description
<p>Diagnostic Testing</p> <p>Performed in a PCP Office</p> <p>Performed in a Specialist Office</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	50% Coinsurance after Deductible	
<p>Dialysis</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Center or Specialist Office Setting</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan Year</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[Preauthorization; Referral Required]</i></p>	50% Coinsurance after Deductible	60 visits per Plan Year for PT/OT/ST combined
<p>Home Health Care</p> <p><i>[Preauthorization; Referral Required]</i></p>	50% Coinsurance after Deductible	40 visits per Plan Year

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services <i>[Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description Home infusion counts towards Home Health Care visit limits
Inpatient Medical Visits <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Laboratory Procedures		See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Performed in a PCP Office</p> <p>Performed in a Freestanding Laboratory Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	
<p>Maternity & Newborn Care</p> <p>Prenatal Care</p> <p>Inpatient Hospital Services and Birthing Center</p> <p>Physician and Midwife Services for Delivery</p> <p>Breast Pump</p> <p>Postnatal Care</p>	<p>Covered in Full</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>Covered in Full</p> <p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>1 Home Care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization Required [for Inpatient Services; Breast Pump]</i>		
Outpatient Hospital Surgery Facility Charge <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Preadmission Testing <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Services <i>[Preauthorization; Referral Required]</i>		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	60 visits per Plan 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 <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Office Surgery <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education <i>[Preauthorization; Referral Required [for</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible	See benefit for description

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>Insulin Pump]]</i>		
Durable Medical Equipment & Braces <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	Single purchase once Every 3 years
Cochlear Implants <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	One per ear per time Covered
Hospice Care Inpatient Outpatient <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible	210 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	See benefit for description
Prosthetic Devices External	50% Coinsurance after Deductible	One prosthetic device, per limb, per

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Internal</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p>	<p>lifetime</p> <p>Unlimited</p> <p>See benefit for description</p>

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Observation Stay</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>50% Coinsurance after Deductible</p>	<p>See benefit for description</p>

Inpatient Services & Facilities	Participating Provider Member Responsibility for Cost-Sharing	Limits
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	60 days per Plan Year for PT/ST/OT combined

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	50% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive	50% Coinsurance after Deductible	See benefit for description

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Program Services) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>		
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	50% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services <i>[Preauthorization; Referral Required]</i>	50% Coinsurance after Deductible	Unlimited; Up to 20 visits per calendar year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy		
30 Day Supply		See benefit for description

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 1 Tier 2 Tier 3	\$10 Copayment after Deductible \$35 Copayment after Deductible \$70 Copayment after Deductible	
Mail Order Pharmacy		
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	\$25 Copayment after Deductible \$87.50 Copayment after Deductible \$175 Copayment after Deductible	See benefit for description

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

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics)	50% Coinsurance after Deductible 50% Coinsurance after Deductible	One dental exam and cleaning per 6-month period

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Limits
and Prosthodontics) Orthodontics <i>[Orthodontics Require Preauthorization; Referral]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible	
Pediatric Vision Care Exams Lenses & Frames Contact Lenses <i>[Contact Lenses Require Preauthorization; Referral]</i>	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	One exam per 12-month period; One prescribed lenses and frames in a 12-month period

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.

Statement of Variability

The language indicating which benefits require preauthorization or referral has been bracketed. The language will be included only for those services that specifically require the preauthorization or referral.

SECTION XXVII - Liberty POS Schedule of Benefits

Platinum Plan

Cost Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Deductible		
Individual	None	\$1,000
Family	None	\$2,000
Out-of-Pocket Limit		
Individual	\$2,000	\$3,000
Family	\$4,000	\$5,000
		<p>The Allowed Amount is 140% of Medicare. See the Out-of-Network Rider for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.</p>

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	\$15 Copayment	20% Coinsurance after Deductible	See benefit for description
Medications Administered in Office	\$15 Copayment	20% Coinsurance after Deductible	
Specialist Office Visits (or Home Visits)	\$35 Copayment	20% Coinsurance after Deductible	See benefit for description
Medications Administered in Office	\$35 Copayment	20% Coinsurance after Deductible	
<i>[Preauthorization; Referral Required]</i>			
Preventive Care			
Well Child Visits and Immunizations*	Covered in full	20% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Non-Participating Providers services are not covered and you pay the full cost	
Adult Immunizations*	Covered in full	Non-Participating Providers services are not covered and you pay the full cost	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Providers services are not covered and you pay the full cost	
Mammography Screenings*	Covered in full	20% Coinsurance after Deductible	
Sterilization Procedures for Women*	Covered in full	Non-Participating Providers 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)	20% Coinsurance after Deductible	
Bone Density Testing*	Covered in full	Non-Participating Providers services are not covered and you pay the full cost	
Screening for Prostate Cancer	Covered in full	Non-Participating Providers services are not covered and	

Office Visits	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
		you pay the full cost	
All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Providers 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. <i>[Referral Required]</i>	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Providers services are not covered and you pay the full cost	

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)	\$100 Copayment	\$100 Copayment	See benefit for description
Non-Emergency Ambulance Services <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	\$100 Copayment	See benefit for description

Emergency Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Department <i>Copayment/Coinsurance waived if Hospital admission.</i>	\$100 Copayment	\$100 Copayment	See benefit for description
Urgent Care Center <i>[Preauthorization Required for Out-of- Network Urgent Care; Referral Required]</i>	\$55 Copayment	20% Coinsurance after Deductible	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 Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services	\$35 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	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
<i>[Preauthorization; Referral Required]</i>			
Allergy Testing & Treatment Performed in a PCP Office Performed in a Specialist Office <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	20% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	20% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation Performed in a Specialist Office Performed as Outpatient Hospital	\$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance	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
Services Performed as Inpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	Included As Part of Inpatient Hospital Service Cost-Sharing	after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <i>[Preauthorization; Referral Required]</i>	\$15 Copayment \$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Chiropractic Services <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	20% Coinsurance after Deductible	See benefit for description
Diagnostic Testing Performed in a PCP Office Performed in a Specialist Office	\$15 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance	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
<p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	\$35 Copayment	<p>after Deductible</p> <p>20% Coinsurance after Deductible</p>	
<p>Dialysis</p> <p>Performed in a PCP Office</p> <p>Performed in a Freestanding Center or Specialist Office Setting</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$25 Copayment	20% Coinsurance after Deductible	60 visits per Plan Year for PT/OT/ST combined

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>			
Home Health Care <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	20% Coinsurance after Deductible	40 visits per Plan Year
Infertility Services <i>[Preauthorization; Referral Required]</i>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	20% Coinsurance after Deductible	See benefit for description
Infusion Therapy			See benefit for description
Performed in a PCP Office	\$15 Copayment	20% Coinsurance after Deductible	
Performed in Specialist Office	\$15 Copayment	20% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	\$15 Copayment	20% Coinsurance after Deductible	
Home Infusion Therapy	\$15 Copayment	20% Coinsurance after Deductible	Home infusion counts towards

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>			Home Health Care visit limits
Inpatient Medical Visits <i>[Preauthorization; Referral Required]</i>	Covered in Full	20% Coinsurance after Deductible	See benefit for description
Laboratory Procedures Performed in a PCP Office	\$15 Copayment	20% Coinsurance after Deductible	See benefit for description
Performed in a Freestanding Laboratory Facility or Specialist Office	\$35 Copayment	20% Coinsurance after Deductible	
Performed as Outpatient Hospital Services	\$35 Copayment	20% Coinsurance after Deductible	
<i>[Preauthorization; Referral Required]</i>			
Maternity & Newborn Care Prenatal Care	Covered in Full	20% Coinsurance after Deductible	See benefit for description
Inpatient Hospital Services and Birthing Center	\$500 Copayment per admission	20% Coinsurance after Deductible	1 Home Care visit is

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Physician and Midwife Services for Delivery Breast Pump Postnatal Care <i>[Preauthorization Required [for Inpatient Services; Breast Pump]]</i>	\$100 Copayment Covered in Full \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	20% Coinsurance after Deductible	See benefit for description
Preadmission Testing <i>[Preauthorization; Referral Required]</i>	\$0 Copayment	20% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist	\$15 Copayment \$35 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible	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
<p>Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$35 Copayment</p>	<p>20% Coinsurance after Deductible</p>	
<p>Therapeutic Radiology Services</p> <p>Performed in a Freestanding Radiology Facility or Specialist Office</p> <p>Performed as Outpatient Hospital Services</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$25 Copayment</p>	<p>20% Coinsurance after Deductible</p>	<p>60 visits Plan Year for PT/OT/ST combined. Speech and Physical Therapy are only Covered following a Hospital stay or</p>

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
			surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	20% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center	\$100 Copayment \$100 Copayment \$100 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description All Transplants must be performed at Designated Facilities

Professional Services and Outpatient Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Office Surgery <i>[Preauthorization; Referral Required]</i>	\$35 Copayment	20% Coinsurance after Deductible	

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 <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	20% Coinsurance after Deductible	680 Hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder <i>[Preauthorization; Referral Required]</i>	\$15 Copayment	20% Coinsurance after Deductible	See benefit for description
Diabetic Equipment, Supplies & Self-Management Education Diabetic Equipment, Supplies and Insulin (30-Day Supply)	\$15 Copayment	20% Coinsurance after Deductible	See benefit for description

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Diabetic Education</p> <p><i>[Preauthorization; Referral Required [for Insulin Pump]]</i></p>	\$15 Copayment	20% Coinsurance after Deductible	
<p>Durable Medical Equipment & Braces</p> <p><i>[Preauthorization; Referral Required]</i></p>	10% Coinsurance	20% Coinsurance after Deductible	See benefit for description
<p>External Hearing Aids</p> <p><i>[Preauthorization; Referral Required]</i></p>	10% Coinsurance	20% Coinsurance after Deductible	Single purchase once Every 3 years
<p>Cochlear Implants</p> <p><i>[Preauthorization; Referral Required]</i></p>	\$15 Copayment	20% Coinsurance after Deductible	One per ear per time Covered
<p>Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p><i>[Preauthorization; Referral Required]</i></p>	<p>\$500 Copayment per admission</p> <p>\$15 Copayment</p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>210 days per Plan Year</p> <p>5 visits for family bereavement counseling</p>

Additional Services, Equipment & Devices	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Supplies <i>[Preauthorization; Referral Required]</i>	10% Coinsurance	20% Coinsurance after Deductible	See benefit for description
Prosthetic Devices External Internal <i>[Preauthorization; Referral Required]</i>	10% Coinsurance 10% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime Unlimited See benefit for description

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) <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission	20% Coinsurance after Deductible	See benefit for description
Observation Stay <i>[Preauthorization; Referral Required]</i>	\$100 Copayment	\$100 Copayment	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission	20% Coinsurance after Deductible	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <i>[Preauthorization; Referral Required]</i>	\$500 Copayment per admission	20% Coinsurance after Deductible	60 days per Plan 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) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$500 Copayment per admission	10% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$15 Copayment	10% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) <i>[Preauthorization; Referral Required. However Preauthorization is not Required for Emergency Admissions.]</i>	\$500 Copayment per admission	10% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services	\$15 Copayment	10% Coinsurance after Deductible	Unlimited; Up to 20 visits per calendar

Mental Health & Substance Use Disorder Services	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Preauthorization; Referral Required]</i>			year may be used for family counseling

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	\$10 Copayment \$30 Copayment \$60 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Mail Order Pharmacy			
Up to a 90 Day Supply		Non-Participating	See benefit for

Prescription Drugs	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 1 Tier 2 Tier 3	\$25 Copayment \$75 Copayment \$150 Copayment	Provider services are not covered and You pay the full cost	description

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 6 month period; up to an additional \$100 per 6 month period for Spouse

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care Preventive Dental Care Routine Dental Care Major Dental (Endodontics, Periodontics and Prosthodontics) Orthodontics <i>[Orthodontics Preauthorization; Referral]</i>	\$15 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	One dental exam and cleaning per 6-month period
Pediatric Vision Care Exams Lenses & Frames Contact Lenses	\$15 Copayment 10% Coinsurance 10% Coinsurance	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	One exam per 12- month period; One prescribed lenses and frames in a 12-month period

Pediatric Dental & Vision Care	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<i>[Contact Lenses Require Preauthorization; Referral]</i>			

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.

Statement of Variability

The language indicating which benefits require preauthorization or referral has been bracketed. The language will be included only for those services that specifically require the preauthorization or referral.

SERFF Tracking #:

UHLC-129581419

State Tracking #:

2014060277

Company Tracking #:**State:**

New York

Filing Company:

Oxford Health Plans (NY), Inc.

TOI/Sub-TOI:

HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005B Individual - Point-of-Service (POS)

Product Name:

2015 OHP IND OFFX Plans

Project Name/Number:

2015 OHP IND OFFX Plans/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual	OHPNY_Ind_COC_2014	New		2015 Ind OHP Off-Exch Rate Manual.pdf,
2		Underwriting guidelines	OHPNY_Ind_COC_2014	New		Oxford Individual Underwriting Guidelines.final.pdf,

Oxford Health Plans (NY), Inc.

New York Individual

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Rate Manual

Rates Effective January 1, 2015

Oxford Health Plans (NY), Inc.
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Oxford Health Plans (NY), Inc.
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 Area Factors

Area Factor is "n/a" for counties outside the service area.

County	DFS Rating Region	Area Factor	County	DFS Rating Region	Area Factor	County	DFS Rating Region	Area Factor
Albany	1	n/a	Delaware	3	n/a	Broome	6	n/a
Columbia	1	n/a	Dutchess	3	1.000	Cayuga	6	n/a
Fulton	1	n/a	Orange	3	1.000	Chemung	6	n/a
Greene	1	n/a	Putnam	3	1.000	Cortland	6	n/a
Montgomery	1	n/a	Sullivan	3	1.000	Onondaga	6	n/a
Rensselaer	1	n/a	Ulster	3	1.000	Schuyler	6	n/a
Saratoga	1	n/a	Bronx	4	1.000	Steuben	6	n/a
Schenectady	1	n/a	Kings	4	1.000	Tioga	6	n/a
Schoharie	1	n/a	New York	4	1.000	Tompkins	6	n/a
Warren	1	n/a	Queens	4	1.000	Chenango	7	n/a
Washington	1	n/a	Richmond	4	1.000	Clinton	7	n/a
Allegany	2	n/a	Rockland	4	1.000	Essex	7	n/a
Cattaraugus	2	n/a	Westchester	4	1.000	Franklin	7	n/a
Chautauqua	2	n/a	Livingston	5	n/a	Hamilton	7	n/a
Erie	2	n/a	Monroe	5	n/a	Herkimer	7	n/a
Genesee	2	n/a	Ontario	5	n/a	Jefferson	7	n/a
Niagara	2	n/a	Seneca	5	n/a	Lewis	7	n/a
Orleans	2	n/a	Wayne	5	n/a	Madison	7	n/a
Wyoming	2	n/a	Yates	5	n/a	Oneida	7	n/a
						Oswego	7	n/a
						Otsego	7	n/a
						St. Lawrence	7	n/a
						Nassau	8	1.000
						Suffolk	8	1.000

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Base Medical and Prescription Drug Rates

All Counties in the Service Area have identical rates.

Effective Year	Metal	Plan	Single Rate	Parent / Child(ren) Rate	Couple Rate	Family Rate	Child Only Rate
2015	Bronze	Oxford Individual Standard Gated EPO \$3,000	\$ 586.53	\$ 997.10	\$1,173.06	\$1,671.61	\$ 241.65
2015	Silver	Oxford Individual Standard Gated EPO \$2,000	\$ 700.18	\$1,190.31	\$1,400.36	\$1,995.51	\$ 288.47
2015	Gold	Oxford Individual Standard Gated EPO \$600	\$ 827.73	\$1,407.14	\$1,655.46	\$2,359.03	\$ 341.02
2015	Platinum	Oxford Individual Standard Gated EPO	\$ 976.99	\$1,660.88	\$1,953.98	\$2,784.42	\$ 402.52

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Ancillary Coverage Rider Rates

Dependent Age Cut-off 29 25.10% load to Med+Rx base rate, for all quarters, tiers, and areas.

Platinum POS 9.04% load to Med+Rx base rate, for all quarters, tiers, and areas.

- \$ 1,000 Individual Deductible
- \$ 2,000 Family Deductible
- 20% Coinsurance
- \$ 3,000 Individual Maximum Out-of-pocket
- \$ 5,000 Family Maximum Out-of-pocket

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 Medical and Rx Drug Benefits

INN = In-Network, OON = Out-of-network, Ded = Deductible, Coin = Coinsurance, MOOP = Maximum Out-of-pocket inc. Deductible,
 STD = Subject to Deductible, IP = Inpatient, OP = Outpatient, D&C = Subject to Ded and Coin.

The key to the Prescription Drug plans is on a following page.

Plan Name	Oxford Individual Standard Gated EPO \$3,000	Oxford Individual Standard Gated EPO \$2,000	Oxford Individual Standard Gated EPO \$600	Oxford Individual Standard Gated EPO
Metal	Bronze	Silver	Gold	Platinum
Preventive	100%	100%	100%	100%
INN Ded	\$3,000	\$2,000	\$600	\$0
INN Coin	50%	30%	20%	10%
INN MOOP	\$6,350	\$5,500	\$4,000	\$2,000
OON Ded	n/a	n/a	n/a	n/a
OON Coin	n/a	n/a	n/a	n/a
OON MOOP	n/a	n/a	n/a	n/a
Family Ded	2x Single	2x Single	2x Single	2x Single
Family MOOP	2x Single	2x Single	2x Single	2x Single
PCP Copay	D&C	\$30	\$25	\$15
PCP STD?	n/a	Y	Y	N
Spec Copay	D&C	\$50	\$40	\$35
Spec STD?	n/a	Y	Y	N
ER Copay	D&C	\$150	\$150	\$100
ER STD?	n/a	Y	Y	N
INN OP Surg Copay - ASC	D&C	\$100	\$100	\$100
INN OP Surg - ASC STD?	n/a	Y	Y	N
INN OP Surg Copay - Hospital	D&C	\$100	\$100	\$100
INN OP Surg - Hospital STD?	n/a	Y	Y	N
INN IP Copay	D&C	\$1,500	\$1,000	\$500
INN IP STD?	n/a	Y	Y	N
INN IP Copay Max	n/a	n/a	n/a	n/a
IP Copay per Admit / Day	n/a	Admit	Admit	Admit
PCP Gated?	Y	Y	Y	Y
Network	Liberty	Liberty	Liberty	Liberty
Prescription Drugs	N	E	E	D

Oxford Health Plans (NY), Inc.
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 Prescription Drug Benefit Key

Format is [Generic]/[Brand Formulary]/[Brand Non-Formulary].

Letter Code	Prescription Drug Plan
A	\$10/\$20/\$40
B	\$10/\$20/\$50
C	\$10/\$25/\$50
D	\$10/\$30/\$60
E	\$10/\$35/\$70
F	\$10/\$35/\$75
G	\$10/\$65/50% to \$800
H	\$15/50%/50%
I	\$7/\$20/\$40
J	Ded Med/RX then \$10/\$20/\$50
K	Ded Med/RX then \$10/\$25/\$50
L	Ded Med/RX then \$10/\$30/\$60
M	Ded Med/Rx then \$10/\$35/\$60
N	Ded Med/Rx then \$10/\$35/\$70
O	Ded Med/RX then \$10/\$35/\$75
P	Ded Med/Rx then \$10/30%, max \$150/45%, max \$400
Q	Ded Med/Rx then \$15/\$35/\$75
R	Ded Med/RX then \$15/50%/50%
S	Ded Med/Rx then \$20/\$40/\$80
T	Ded Med/Rx then 0%/0%/0%
U	Non-T1 Ded \$100 then \$10/\$25/\$50
V	Non-T1 Ded \$100 then \$10/\$30/\$60
W	Non-T1 Ded \$100 then \$10/\$35/\$60
X	Non-T1 Ded \$100 then \$10/50%/50%
Y	Non-T1 Ded \$100 then \$15/\$30/\$60
Z	Non-T1 Ded \$100 then \$15/\$35/\$75
AA	Non-T1 Ded \$100 then \$15/50%/50%
AB	Non-T1 Ded \$100 then \$7/\$20/\$40
AC	Non-T1 Ded \$150 then \$10/\$25/\$50
AD	Non-T1 Ded \$150 then \$15/50%/50%
AE	Non-T1 Ded \$250 then \$10/\$25/\$50
AF	Non-T1 Ded \$250 then \$10/\$30/\$60
AG	Non-T1 Ded \$250 then \$15/50%/50%
AH	Non-T1 Ded \$250 then \$5/20%, max \$150/35%, max \$400
AI	Non-T1 Ded \$250 then \$7/\$20/\$40
AJ	Non-T1 Ded \$50 then \$10/\$25/\$50
AK	Non-T1 Ded \$50 then \$15/\$35/\$75
AL	Non-T1 Ded \$50 then \$15/50%/50%
AM	Non-T1 Ded \$50 then \$7/\$20/\$40
AN	Non-T1 Ded \$500 then \$10/\$25/\$50
AO	Non-T1 Ded \$500 then \$10/\$30/\$60
AP	Non-T1 Ded \$500 then \$15/50%/50%
AQ	Non-T1 Ded Med/Rx then \$10/30%, max \$150/45%, max \$400
AR	Non-T1 Ded Med/Rx then \$10/50%, max \$150/50%, max \$400
AS	Non-T1 Ded Med/Rx then \$15/\$35/\$75

Oxford Health Plans (NY), Inc.
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 Pediatric Dental and Vision Benefits

Benefit Category	
EHB - Prev & Diagnostic -Ped Dental (for children)	PCP cost share
Ped Dental Ded (Applies to - Basic Dental Svcs, Major Dental Svcs, Orthodontia, or any combination)	Basic, Major, Preventive & Diagnostic, Orthodontia
INN Ped Dental Single Ded	* N/A if copay * Ded if D&C
INN Ped Dental Family Ded	* N/A if copay * Ded if D&C
EHB - Basic Dental Svcs (e.g. Fillings/extractions) for Children	PCP cost share
EHB - Major Dental Svcs (e.g. Crowns) for Children	PCP cost share
EHB - Orthodontia (e.g. braces) for Children	PCP cost share
Ped Vision Ded (\$/N/A/Inc in Med)	* N/A if copay * Ded if D&C
Ped Vision Ded (Applies to - Routine Vision Exam, Vision Materials, or both)	* N/A if copay * Ded if D&C
EHB - Routine Vision Exam for Children	PCP cost share
EHB - Prev Lens copay for Children	INN coins
EHB - Prev Frames Tier 1 for Children	INN coins
EHB - Prev Frames Tier 2 for Children	INN coins
EHB - Prev Frames Tier 3 for Children	INN coins
EHB - Prev Frames Tier 4 for Children	INN coins
EHB - Prev Frames Tier 5 for Children	INN coins
EHB - Prev Contacts for Children	INN coins

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 Additional Notes

Estimated Commissions as a percent of premium: 1.5%

Expected Loss Ratio (Claims / Premium): 82.0%

To determine the premium rate for a plan design, first look up the rate for that plan design, demographic tier, and area. Then add the rate for any riders, for the demographic tier and area. The total is the final rate.

Sample Calculation

Oxford Individual Standard Gated EPO
 Dependent Age Cut-off 29 Rider, Platinum POS Rider

Tier:	Medical + Rx Rate	Dependent Age Cut-off 29	Platinum POS	Total Rate
Single rate	\$ 976.99	\$ 245.22	\$ 88.32	\$ 1,310.53
Parent / Child(ren) rate	\$ 1,660.88	\$ 416.88	\$ 150.14	\$ 2,227.90
Couple rate	\$ 1,953.98	\$ 490.45	\$ 176.64	\$ 2,621.07
Family rate	\$ 2,784.42	\$ 698.89	\$ 251.71	\$ 3,735.02

Oxford Health Plans (NY), Inc. New York Individual Underwriting Guidelines

Eligibility Rules - We will follow the eligibility rules in our individual Certificate(s) of Coverage. These rules include details on the open and special enrolment periods and the Service Area for our products. To be eligible, a covered member must live, work or reside in Our Service Area

Service Area - Our Oxford Individual Service Area consists of the counties where we are licensed and authorized to sell individual products and have approved products and rates. Currently, our Service Area consists of Bronx, Dutchess, Kings, New York, Orange, Putnam, Queens, Richmond, Rockland, Nassau, Suffolk, Sullivan, Ulster and Westchester counties.

State: New York **Filing Company:** Oxford Health Plans (NY), Inc.
TOI/Sub-TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005B Individual - Point-of-Service (POS)
Product Name: 2015 OHP IND OFFX Plans
Project Name/Number: 2015 OHP IND OFFX Plans/

Supporting Document Schedules

Bypassed - Item:	Rate Filing Instructions for On and Off Exchange Plans
Bypass Reason:	Per description above, this is a reference only section.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum/Actuarial Certification
Comments:	Cover Letter Actuarial Memo Actuarial Cert
Attachment(s):	2015 OHP Individual Cover letter.pdf 2015 OHP Individual Certification.pdf 2015 Ind OHP Off-Exch Act Memo.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	2015 IND OHP Off Exchange URRT Part III.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Value Calculations
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch AVs.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 13-Narrative Summary and Numerical Summary
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 13.pdf 2015 Ind OHP Off-Exch Ex 13.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Exhibit 14A-Indiv Requested Percentage Changes
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SERFF Tracking #:

UHLC-129581419

State Tracking #:

2014060277

Company Tracking #:

State: New York
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: 2015 OHP IND OFFX Plans
Project Name/Number: 2015 OHP IND OFFX Plans/

Filing Company:

Oxford Health Plans (NY), Inc.

Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 14.pdf 2015 Ind OHP Off-Exch Ex 14.xlsx
Item Status:	
Status Date:	
Bypassed - Item:	Exhibit 14B-Sm Grp Requested Percentage Changes
Bypass Reason:	N/A This is an individual filing
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 15A-Indiv Distribution by Rate Adj Percentages
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 15.pdf 2015 Ind OHP Off-Exch Ex 15.xlsx
Item Status:	
Status Date:	
Bypassed - Item:	Exhibit 15B-Sm Grp Distribution by Rate Adj Percentages
Bypass Reason:	N/A This is an individual filing
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 16-Summary of Policy Form & Product Changes
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 16.pdf 2015 Ind OHP Off-Exch Ex 16.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 17-Claims Experience for 2011-13 (Sm Grps)
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 17.pdf 2015 Ind OHP Off-Exch Ex 17.xlsx
Item Status:	
Status Date:	

SERFF Tracking #:

UHLC-129581419

State Tracking #:

2014060277

Company Tracking #:

State: New York **Filing Company:** Oxford Health Plans (NY), Inc.
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: 2015 OHP IND OFFX Plans
Project Name/Number: 2015 OHP IND OFFX Plans/

Satisfied - Item:	Exhibit 18-Index Rate Plan-Design Development
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 18.pdf 2015 Ind OHP Off-Exch Ex 18.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 19-Claim Trend, Admin Expenses & Profit
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 19.pdf 2015 Ind OHP Off-Exch Ex 19.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 20-HIOS ID Mapping
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 20.pdf 2015 Ind OHP Off-Exch Ex 20.xlsx
Item Status:	
Status Date:	
Satisfied - Item:	Exhibit 23-Requested 2015 Premium Rates
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch Ex 23.pdf 2015 Ind OHP Off-Exch Ex 23.xlsx
Item Status:	
Status Date:	
Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Must bypass this Requirement at initial submission since the required documentation is not yet available on HIOS/HHS.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Initial Notice of Proposed Rate Adjustment
Comments:	PDF version of the Individual Initial Notice.
Attachment(s):	Rate Review_Initial Notice OHP IND_Off-Exchange Individual.pdf
Item Status:	

SERFF Tracking #:

UHLC-129581419

State Tracking #:

2014060277

Company Tracking #:

State: New York
TOI/Sub-TOI: HOrg021 Individual Health Organizations - Health Maintenance (HMO)/HOrg021.005B Individual - Point-of-Service (POS)
Product Name: 2015 OHP IND OFFX Plans
Project Name/Number: 2015 OHP IND OFFX Plans/

Status Date:	
Satisfied - Item:	Final Notice of Proposed Rate Adjustment
Comments:	
Attachment(s):	DRAFT 2015 Individual Final Notification Letter.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Redacted Documents for Web Posting
Comments:	
Attachment(s):	2015 IND OHP Off Exchange URRT Part III_redacted.pdf 2015 Ind OHP Off-Exch Ex 11 - redacted.pdf 2015 Ind OHP Off-Exch Ex 21A- redacted.pdf 2015 OHP Individual Cover letter - redacted.pdf 2015 Ind OHP Off-Exch Ex 21B - redacted.pdf 2015 OHP Individual Certification - redacted.pdf 2015 Ind OHP Off-Exch Ex 11 - redacted.xlsx 2015 Ind OHP Off-Exch Ex 21A- redacted.xlsx 2015 Ind OHP Off-Exch Ex 21B - redacted.xlsx 2015 Ind OHP Off-Exch Ex 22_redacted.xlsx 2015 Ind OHP Off-Exch Ex 22_redacted.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	2015 Ind OHP Off-Exch URRT.pdf 2015 Ind OHP Off-Exch URRT.xlsm
Item Status:	
Status Date:	

State:	New York	Filing Company:	Oxford Health Plans (NY), Inc.
TOI/Sub-TOI:	HOrg02I Individual Health Organizations - Health Maintenance (HMO)/HOrg02I.005B Individual - Point-of-Service (POS)		
Product Name:	2015 OHP IND OFFX Plans		
Project Name/Number:	2015 OHP IND OFFX Plans/		

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Attachment 2015 Ind OHP Off-Exch Ex 22_redacted.xlsx is not a PDF document and cannot be reproduced here.

Attachment 2015 Ind OHP Off-Exch URRT.xlsm is not a PDF document and cannot be reproduced here.



June 13, 2014

[REDACTED]
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: Oxford Health Plans (NY), Inc.
NY Individual Off-Exchange
Effective January 2015 – December 2015

Dear [REDACTED]

This rate filing addresses the development of the New York Individual Off-Exchange rates for plans written by Oxford Health Plans (NY), Inc. The rates are effective from January 2015 to December 2015.

Should you have any questions or need any additional information, please contact me at [REDACTED]

[REDACTED]

[REDACTED]



Oxford Health Plans (NY), Inc.

New York Individual
Rates Effective January 1, 2015 – December 31, 2015

ACTUARIAL CERTIFICATION

I [REDACTED] am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
 - ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Clarification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/ Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

[REDACTED]

June 13, 2014

UnitedHealthcare



Oxford Health Plans (NY), Inc.
New York Individual Off-Exchange Rates
HIOS ID: 26420
Effective January 2015 – December 2015

ACTUARIAL MEMORANDUM

I. Introduction

This rate filing addresses the rate development for the New York Individual Off-Exchange plans written by Oxford Health Plans (NY), Inc. (“OHP”). We plan to offer the New York state-defined standard plan designs in the Individual Off-Exchange market as required by New York. Rates are effective from January 1, 2015 through December 31, 2015. This rate filing is being submitted under Section 4308(c) of the New York State Insurance Law.

The rates for the Individual Exchange plans written by UnitedHealthcare of New York, Inc. (“UHC”) were also filed with the New York State Department of Financial Services (“DFS”) on June 13, 2014. The rate level for the Off – Exchange plans included in this filing is the same as the Exchange rate level except for an adjustment to reflect network differences.

II. Determination of the Index Rate

A. Experience Period Claims

Please refer to Exhibit 18 for the development of the index rate. Because the Individual product is new, we used Oxford Health Insurance, Inc. (“OHI”) small group claims data with additional adjustments as described in this Actuarial Memorandum to calculate the Individual Off-Exchange rates. Specifically, we used OHI’s small group claims incurred between January 1, 2013 and December 31, 2013 paid through February 28, 2014 with an adjustment for claims incurred but not reported (“IBNR”). We excluded experience for sole proprietors consistent with the pricing/filing instructions issued by the New York State Department of Financial Services (“DFS”). The experience includes all other groups active in the period. There are no OHI Small Group grandfathered plans so no exclusion was required. Regulation 146 amounts were removed from the experience period claims. The resulting in-network only experience period claim PMPM excluding Regulation 146 is \$416.63.

B. Average AV Pricing Value

We used the UnitedHealthcare proprietary pricing model to determine the pricing actuarial values (“AVs”) for each of the in-force small group plans on the OHI license. We also assigned gatekeeper and network factors to each existing in-force plan using our latest estimated adjustments. The estimated gatekeeper adjustment is -4.0 %, and the estimated Liberty network adjustment is -3.0% versus the Freedom network. Both of these

adjustments apply to medical in-network rates only. We then calculated the average pricing AVs, gatekeeper, and network factors based upon the membership distribution within the experience period for OHI. These are shown below.

In-Network Pricing Actuarial Value (AV) Excluding Gatekeeper & Network 0.805	
Average Gatekeeper and Network Benefit Adjustment	0.987

C. Average Induced Demand Adjustment

The induced demand adjustments used in the 2015 rate development are shown below.

Bronze 0.7779
 Silver 0.8012
 Gold 0.8401
 Platinum 0.8946

The resulting factors normalized to the bronze metal level are as follows and fall within the maximum values permitted by DFS.

Bronze 1.00
 Silver 1.03
 Gold 1.08
 Platinum 1.15

We assigned the induced demand factors above to each in-force plan design based upon its HHS calculator metal level and calculated the average induced demand factor of 0.844 for the experience period.

D. Trend Assumptions

The projected annual trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

We have trended the small group experience period claim PMPM using the 10.9% annual trend factor and the 25 months between the midpoint of the experience period (July 1, 2013) and the midpoint of the first quarter 2015 rating period (August 1, 2015). Please note that the midpoint of the rating period assumes an average effective date of February 1, 2015 for groups new or renewing in the first quarter of 2015.

The small group trended incurred in-network claim PMPM of \$517.32 was calculated by multiplying the experience period incurred in-network claim PMPM of \$416.63 by the trend factor of 1.242.

E. Projected Average PMPM Claims

We have calculated the experience-period in-network index rate PMPM adjusted for AV, induced demand, and gating and network provisions of \$618.45. The small group trended AV-adjusted experience period in-network index rate PMPM is \$767.93.

F. Market-Wide Index Rate Adjustments

The development of the market wide adjustments is described below.

1. Federal Risk Adjustment: We have assumed a risk transfer factor of 1.000 for the Individual Off-Exchange product since it will be new and the expected cost is based upon an adjustment to the Small Group claims experience which has already been normalized to the statewide average risk level. The projected difference between the Individual and Small Group risk levels is reflected in the morbidity adjustment described below.
2. Federal Transitional Reinsurance Program: We have estimated that we will receive 7.4% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and OHI small group, Healthy NY, and Individual to 2015 and then running the trended claims through the federal reinsurance formula. While the expected Individual cost level is higher than Small Group, we have not adjusted for this due to the potential for a funding shortfall.
3. Exchange User Fees: As instructed by DFS, we have not included an adjustment for exchange user fees in the 2015 premium rates. We understand this instruction is due to the fact that the 2014-2015 Executive Budget does not include any Exchange user fees.
4. Essential Health Benefits: The Essential Health Benefits (“EHB”) adjustments described in this section were applied in the OHI small group claim projection that is being used to calculate the Individual Off-Exchange rates. While the Oxford EPO plan was chosen as the benchmark plan, there are some required modifications to comply with the EHB provision of PPACA. These changes and the estimated claim impacts are as follows.

Removal of \$1,500 DME Maximum	0.8%
Clinical Trials	0.03%
Habilitative Benefits	0.2%
Federal Mental Health Parity	0.6%
Total	1.6%

The claim cost estimates for these services were developed using national UnitedHealthcare data and the proprietary UnitedHealthcare pricing model.

The OHI Small Group EHB line also includes an additional 0.5% adjustment to add pharmacy claims for the groups that did not have pharmacy coverage during the experience period. This adjustment was developed based upon the average pharmacy

claim PMPM.

5. Provider Network & Fee Schedule Changes: The Individual Off – Exchange product on the OHP license will utilize the existing Oxford Liberty network.
6. Utilization Management Changes: This is not applicable since this is a new product.
7. Expected Covered Membership Risk: Consistent with the instructions from DFS, we have developed a morbidity adjustment to apply to the 2015 OHI small group rates. We also applied additional adjustments as described in this memorandum to calculate the proposed Individual Off-Exchange rates.

Based upon the statewide Individual enrollment data distributed by DFS, we determined that the age/sex factor for the 2014 Individual enrollees is 15.6% higher than the factor for statewide 2014 Small Group enrollees. Please note that we used NY OHI Large Group filed age/sex factors in this calculation. In addition to this actual demographic difference, we are estimating that the morbidity of the Individual enrollees is 5% higher than Small Group morbidity. Combining the impacts of demographics and morbidity since we cannot rate by age in New York, we expect the Individual cost level to be 21.4% higher than the Small Group cost level in 2015.

8. Distribution of Membership by Rating Region: This is not applicable since this is a new product.
9. Credibility Adjustment: We used the OHI small group business to price the Individual Exchange rates. We had an average of 432,303 members in OHI small group plans during the experience period. We consider this to be fully credible and therefore have made no adjustments.

III. Determination of the Premium Rates

A. Plan Level Adjustments

1. Pricing Actuarial Values: Consistent with the calculation of the average pricing AV values for the experience period, we also used the UnitedHealthcare proprietary pricing model to determine the AVs for each of the Individual Off-Exchange plans on the OHP license.
2. Induced Demand Adjustments: The development of the induced demand factors is described in Section II(C). We used the same values to calculate the new plan rates as were used to calculate the average induced demand adjustment for the experience period. These values are as follows:

Bronze 0.7779
Silver 0.8012
Gold 0.8401
Platinum 0.8946

3. Provider Network Characteristics: Consistent with the values used to calculate the average experience period network value, we have assumed 1.0 for Freedom and 0.976 for Liberty. These factors apply to total rates.
4. Delivery System Characteristics: Consistent with the values used to calculate the average experience period gatekeeper value, we have assumed 1.0 for non-gatekeeper and 0.96 for gatekeeper. These factors apply to the in-network medical portion of the rates only.
5. Utilization Management Practices: This is not applicable since this is a new product.
6. Benefits in Addition to EHB: We are not adding any benefits in addition to EHB that would require a rate adjustment.
7. Administrative Costs (Excluding Exchange User Fees and Profits): The projected 2015 expense percentage for OHP Off-Exchange Individual is 15.2% excluding exchange user fees and profits. This includes administration (6.8%), commissions (1.5%), state premium taxes (3.2%), the PPACA insurer fee (3.2%), and the PPACA reinsurance fee (0.5%). The 1.5% commission percentage reflects \$15 PEPM.
8. Profit: The requested rates reflect an 85.2% target BCR before the application of the PPACA fees and assessments and 82.0% after the application of the PPACA fees and assessments. This reflects projected profit of 2.7% for OHP Individual based upon premium including the PPACA fees and assessments. The projected loss ratio using federally prescribed MLR methodology is 88.2%.
9. SMC Rate Credit: On May 14, 2014, DFS instructed United to include a \$16.3M credit in the 2015 Individual rates due to an SMC Pool overage. As discussed with DFS, we believe this has been covered off by past credits and distributions. Therefore, we have not applied a credit for this amount. On May 30, 2014, DFS instructed United to include a \$220K credit in the 2015 Individual rates due to an SMC Pool overage for 1999-2004. After netting out the remaining \$70K credit based upon previous distributions and credits, the net amount to include as a credit to 2015 rates is \$150K. This resulting credit is 0.1% based upon projected plan year 2015 premium.

B. Census Factors

The requested premium rates reflect the state-mandated tier factors as shown in the table below. We calculated the PMPM-to-single conversion factor of 1.241 using the combined OHP and OHI Small Group distribution of members and subscribers for January 2014 as shown in the table below and then adjusted the factor by the ratio of the experience period cost level to the January 2014 cost level. Since there has been a change in contract distribution from 2013 to 2014, we believe this approach most accurately captures this change while still being consistent with the 2013 cost level.

Oxford Small Group Total				
Tier	Members	Subs	Relativity	Conversion Factor

Single	26,019	26,019	1.000	1.262
Parent/Child(ren)	10,005	3,490	1.700	
Couple	10,020	5,010	2.000	
Family	43,040	10,036	2.850	

As described above, we applied a factor of .983 to the 1.262 conversion factor to make the conversion factor consistent with the 2013 cost level. The resulting final conversion factor is 1.241.

C. Area Factors

We propose area factors of 1.0 for all regions.

IV. Supporting Details

A. HHS Actuarial Value Calculator Adjustments

DFS determined the metal levels for the new state-mandated plans.

B. Trend

We develop forward-looking medical expense estimates based on a number of considerations. As a general matter, we review our own recent/emerging claims experience at the state level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Forward looking utilization levels are developed based on emerging state level data, supplemented by regional and/or national level utilization data. Macro-economic data is often used to develop assumptions regarding directional changes in national health care consumption rates.

The projected annual trend factor is 10.9%. This breaks down into the following components: 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging. Please note that this trend factor excludes any risk margin.

C. Administrative Costs

The projected 2015 expense percentage for OHP Off-Exchange Individual is 15.2% excluding exchange user fees and profits but including PPACA fees and assessments. The increase in projected expenses is due to the incremental increase in the PPACA Insurer Fee, a decrease in the projected premium PMPMs, and the use of expense projections specific to this segment.

D. Profit Assumptions

The requested rates reflect an 85.2% target loss ratio before PPACA fees and assessments. The target loss ratio is 82.0% after PPACA fees and assessments consistent with guidance from DFS. The resulting projected profit percentage is 2.7% relative to premium including PPACA fees.

We have not included a projection of return on equity since this is a new product.

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For Oxford Health Plans (NY), Inc.

State of New York Rate Review

General Information

Purpose: The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT).

Company Identifying Information:

- **Company Legal Name:** Oxford Health Plans (NY), Inc.
- **State:** New York
- **HIOS Issuer ID:** 26420
- **Market:** Individual
- **Effective Date:** 1/1/2015 – 12/31/2015

Company Contact Information:

- **Primary Contact Name:** [REDACTED]
- **Primary Contact Telephone Number:** [REDACTED]
- **Primary Contact Email Address:** [REDACTED]

Proposed Rate Increase

Oxford Health Plans (NY), Inc. ("OHP") is filing rates for benefit plans written under existing policy forms and new certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). The average requested annual rate increase is 1.1%.

Reasons for Rate Increase

The rate filing we have made is seeking a change mainly related to a decrease in the projected Individual market cost level. However, medical expenses continue to increase. Medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs.

Experience Period Premiums and Claims

- **Experience Period:** There is no experience period data to report because this is a new product.
- **Premiums (net of MLR Rebate) in Experience Period:** There is no experience period data to report because this is a new product.
- **Allowed and Incurred Claims Incurred During the Experience Period:** There is no experience period data to report because this is a new product.

Benefit Categories

There is no experience period data to report because this is a new product.

Projection Factors

Projection factors were not used since there are no experience period claims to project for this new product.

Credibility

Because the Individual Off-Exchange product is new, we have no claims experience to project forward in the development of the rates. At the direction of the New York State Department of Financial Services ("DFS"), we adjusted the index rate for Oxford Health Insurance, Inc. ("OHI") small group by a morbidity adjustment to calculate the Individual rates. The development of the OHI small group index PMPM is described in the Part III Actuarial Memorandum for the OHI Small Group Filing (HIOS ID 85629). Based upon the statewide Individual enrollment data distributed by DFS, we determined that the age/sex factor for the 2014 Individual enrollees is 15.6% higher than the factor for statewide 2014 Small Group enrollees. Please note that we used NY OHI Large Group filed age/sex factors in this calculation. In addition to this actual demographic difference, we are estimating that the morbidity of the Individual enrollees is 5% higher than Small Group morbidity. Combining the impacts of demographics and morbidity since we cannot rate by age in New York, we expect the Individual cost level to be 21.4% higher than the Small Group cost level in 2015.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon an estimated distribution of Individual business in 2015 by metal level and the pricing actuarial values for those new plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** We have assumed a risk transfer factor of 1.000 for the Individual Off-Exchange product since it will be new and the expected cost is based upon an adjustment to the Small Group claims experience which has already been normalized to the statewide average risk level. The projected difference between the Individual and Small Group risk levels is reflected in the morbidity adjustment described above.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$3.32 PMPM for the reinsurance fee. We have estimated that we will receive 7.4% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and OHI small group, Healthy NY, and Individual to 2015 and then running the trended claims through the federal reinsurance formula.

Non-Benefit Expenses and Risk Margin

Proprietary & Confidential

The 8.3% administrative expense load includes general administration (6.8%) and broker commissions (1.5%). We have estimated the expenses included in the development of the proposed rates based upon financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 2.9% before state and federal income taxes and 1.7% after.

Taxes and Fees

The 7.9% includes state premium tax and assessments (3.2%), PPACA Insurer fee (3.2%), and state and federal income taxes (1.4%). This excludes the \$3.32 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 88.2%.

Index Rate

There is no index rate for the experience period because this is a new product. The projected index rate of \$636.53 was calculated by applying the Individual morbidity adjustment to the 1st quarter 2015 OHI index rate.

AV Metal Values

AV metal values were calculated by DFS.

AV Pricing Values

The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. For the gatekeeper adjustment, we have assumed factors of 1.0 for non-gatekeeper and 0.96 for gatekeeper. For the network differences, we have assumed factors of 1.0 for Freedom and 0.97 for Liberty. The OHP Off – Exchange plans will be on the Liberty network. These adjustments do not reflect any differences in anticipated risk status. Please note that the gatekeeper and network factors apply to in-network medical claims only.

Membership Projections

Proprietary & Confidential

We are projecting 110,244 Individual Off-Exchange member months in 2015 which reflects an average of 9,187 members per month. These were estimated in collaboration with our finance and sales teams.

Terminated Products

Not applicable.

Plan Type

Not applicable.

Warning Alerts

Not applicable.

Reliance

Not applicable.

Actuarial Certification

I, [REDACTED] am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- b. Developed in compliance with the applicable Actuarial Standards of Practice,
- c. Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- d. Neither excessive nor deficient.

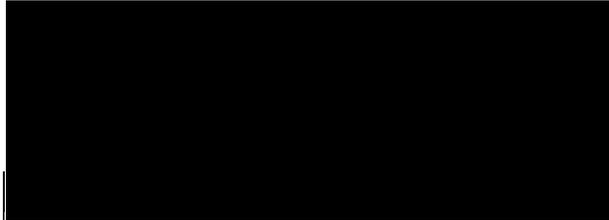
I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is

Proprietary & Confidential

described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.



UnitedHealthcare
48 Monroe Turnpike
Trumbull, CT 06611



Oxford Individual Standard Gated EPO

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
- Apply Inpatient Copay per Day?
- Apply Skilled Nursing Facility Copay per Day?
- Use Separate OOP Maximum for Medical and Drug Spending?
- Indicate if Plan Meets CSR Standard?
- Desired Metal Tier: Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible (\$)	\$0.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$2,000.00		
OOP Maximum if Separate (\$)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined
Deductible (\$)			
Coinsurance (%; Insurer's Cost Share)			
OOP Maximum (\$)			
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input type="checkbox"/>	<input type="checkbox"/>		\$100.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>		\$15.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>		\$500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	96.28%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	93.75%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$60.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

Output

Calculate

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

88.12%

Platinum

Oxford Individual Standard Gated EPO \$600

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
- Apply Inpatient Copay per Day?
- Apply Skilled Nursing Facility Copay per Day?
- Use Separate OOP Maximum for Medical and Drug Spending?
- Indicate if Plan Meets CSR Standard?
- Desired Metal Tier: Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? <input type="checkbox"/>	Blended Network/POS Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$600.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$4,000.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			
Coinsurance (%; Insurer's Cost Share)			
OOP Maximum (\$)			
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$25.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$40.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,000.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	96.12%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	93.22%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input type="checkbox"/>
Specialty Rx Coinsurance Maximum:
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>
Days (1-10):
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>
Visits (1-10):
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>
Copays (1-10):

Output

Calculate

Status/Error Messages:

Calculation Successful.

Actuarial Value:

79.05%

Metal Tier:

Gold

Oxford Individual Standard Gated EPO \$2,000

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
- Apply Inpatient Copay per Day?
- Apply Skilled Nursing Facility Copay per Day?
- Use Separate OOP Maximum for Medical and Drug Spending?
- Indicate if Plan Meets CSR Standard?
- Desired Metal Tier: Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? <input type="checkbox"/>	Blended Network/POS Plan? <input type="checkbox"/>
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$2,000.00	\$0.00	
Coinsurance (%; Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum (\$)	\$5,500.00		
OOP Maximum if Separate (\$)			

	Tier 2 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			
Coinsurance (%; Insurer's Cost Share)			
OOP Maximum (\$)			
OOP Maximum if Separate (\$)			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$150.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$50.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$1,500.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	95.57%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	92.34%		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments? <input type="checkbox"/>	Specialty Rx Coinsurance Maximum:
Set a Maximum Number of Days for Charging an IP Copay? <input type="checkbox"/>	# Days (1-10):
Begin Primary Care Cost-Sharing After a Set Number of Visits? <input type="checkbox"/>	# Visits (1-10):
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? <input type="checkbox"/>	# Copays (1-10):

Output

Calculate

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

70.69%

Silver

Oxford Individual Standard Gated EPO \$3,000

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
- Apply Inpatient Copay per Day?
- Apply Skilled Nursing Facility Copay per Day?
- Use Separate OOP Maximum for Medical and Drug Spending?
- Indicate if Plan Meets CSR Standard?
- Desired Metal Tier: Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>	Blended Network/POS Plan?	<input type="checkbox"/>
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)		\$3,000.00
Coinsurance (%; Insurer's Cost Share)		50.00%
OOP Maximum (\$)		\$6,350.00
OOP Maximum if Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input type="checkbox"/> All			<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$10.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$35.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$70.00	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

Output

Calculate

Status/Error Messages:

Actuarial Value:

Metal Tier:

Calculation Successful.

61.99%

Bronze

EXHIBIT 13: NUMERICAL SUMMARY

Company Name: Oxford Health Plans (NY), Inc.
NAIC Code: 95479
SERFF Tracking #: UHLC-129581419
Market Segment: Individuals Off Exchange

A. Average 2014 and 2015 Premium Rates:

Premium Rates are based on the following criteria:

- 1) The average monthly premium rates for Individual Only.
- 2) The average arithmetic premium rates for all plans combined and for all regions combined.
- 3) Rates include Through Age 29, Domestic Partner and Family Planning Coverages.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	\$1,207.52	\$1,023.29	\$865.30	\$737.98	N/A
2015 Premium Rates	\$1,222.21	\$1,035.49	\$875.93	\$733.75	N/A

B. Weighted Average Annual Percentage Requested Adjustments*:

	2014 to 2015
Requested Rate Adjustment	1.1%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	N/A	N/A	N/A

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

	2011	2012	2013
MLR	N/A	N/A	N/A

E. Claim Trend Rates and Average Ratios to Earned Premiums [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	N/A	10.5%	10.9%
Expense Ratios	N/A	11.3%	15.2%
Pre Tax Profit Ratios	N/A	7.4%	2.7%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.

EXHIBIT 14A

EXHIBIT 14 - PART A: SUMMARY OF REQUESTED PERCENTAGE CHANGES TO EXISTING RATES

-- for Individual Medical Plans

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Tracking #: UHLC-129581419
 Market Segment: Individual Off Exchange

Individual Medical Plan Products

Market Segment	Effective Date of New Rate	Metal Level (or Catastrophic)	Rating Region	Product Name	Product Street Name	Requested Percentage Rate Change		
						Lowest	Highest	Weighted Avg
Individual	1/1/2015	Bronze	99 - All Regions	EPO	EPO	-0.57%	-0.57%	-0.57%
Individual	1/1/2015	Silver	99 - All Regions	EPO	EPO	1.23%	1.23%	1.23%
Individual	1/1/2015	Gold	99 - All Regions	EPO	EPO	1.19%	1.19%	1.19%
Individual	1/1/2015	Platinum	99 - All Regions	EPO	EPO	1.22%	1.22%	1.22%

EXHIBIT 15 - PART A: DISTRIBUTION OF CONTRACTS BY REQUESTED PERCENT ADJUSTMENTS FOR INDIVIDUAL PRODUCTS

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Tracking #: UHL C-129581419
 Market Segment: Individual Off Exchange

Distribution by Requested Rate Adjustment

Market Segment	Effective Date	Metal Level (or Catastrophic)	Rating Region	Weighted Avg Change %	Annualized Premiums as of	Total # of Members as of	Total # of Contracts as of	Number of (*) with Requested Percentage Rate Change at Renewal												
								3/31/2014	Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher	
Individual	1/1/2015	Bronze	99 - All Regions	-0.6%	\$ 3,884,798	681	n/a	681	-	-	-	-	-	-	-	-	-	-	-	-
Individual	1/1/2015	Silver	99 - All Regions	1.2%	\$ 8,267,334	1,236	n/a	-	-	1,236	-	-	-	-	-	-	-	-	-	-
Individual	1/1/2015	Gold	99 - All Regions	1.2%	\$ 8,463,734	1,070	n/a	-	-	1,070	-	-	-	-	-	-	-	-	-	-
Individual	1/1/2015	Platinum	99 - All Regions	1.2%	\$ 36,104,165	3,868	n/a	-	-	3,868	-	-	-	-	-	-	-	-	-	-
Market Segment Total:				1.1%	\$ 56,720,031	6,855	n/a	681	-	6,174	-	-	-	-	-	-	-	-	-	-

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLIC-129581419
 Market Segment: Individual Off Exchange

- 1) Complete a separate ROW for each base medical policy form included in the rate adjustment filing.
 - Information requested applies to New York State business only and for all rating regions combined.
 - Include riders that may be available with that policy form in each policy form response. Discontinued policy forms and products are to be included in the Exhibit.
 - Insert additional rows as needed to include all base medical policy forms included in a particular market segment for Small Groups, Small Group Sole Proprietors and Small Group HNY Business.
 - Add a row with the aggregate values for that entire market segment (including any Small Group Healthy NY and enter an appropriate identifier in column 1b (such as TOTAL).
- 2) In Column 4, market segment refers to Small Group, Small Group Sole Proprietors and Small Group Healthy NY Business.
- 3) Product type is HMO, HMO based POS, POS-OON, EPO, PPO, Comprehensive Major Medical, Non-HMO based POS, and Consumer Health Plans. Indicate appropriate designation for policy form, etc.
- 4) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with DFS.
- 5) Paid claims in Columns 14.6, 15.6 and 16.6 are all claims paid during experience period regardless of incurred dates.
- 6) Note that many cells include a drop down list. Use the drop down list for entries.
- 7) If members, covered lives or member months are not known, use reasonable estimates (note methodology used in the actuarial memorandum).
- 8) This exhibit must be submitted as an Excel file and as a PDF file. Only use the first tab for data entry.

Data Item for Specified Base Medical Policy Form										Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)												
1a. Base medical policy form number	1b. Product Name as in Rate Manual	1c. Product Street Name as indicated to consumers	2. Rating Pool Identification	3. Effective date of rate change (mm/dd/yy)	4. Market Segment [drop down menu]	5. Product type (see above for examples) [drop down menu]	6. Is a rolling rate structure used for this base medical policy form? (Yes or No) [drop down menu]	7. Is base medical policy form open (new sales allowed) or closed (no new sales) [drop down menu]	8. Number of policyholders affected by rate change. (For group business this is number of groups.)	9. Number of covered lives affected by rate change	14.1 Beginning Date of the experience period (mm/dd/yy)	14.2 Ending Date of the experience period (mm/dd/yy)	14.3 Member months for experience period	14.4 Earned premiums for experience period (\$)	14.5 Standardized earned premiums for experience period (\$)	14.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from payments to the Regulation 146 pool or federal risk sharing pool (\$)	14.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from payments to the Regulation 146 pool or federal risk sharing pool (\$)	14.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools as a negative value (\$)	14.9 Adjustment to the incurred claims for the period due to payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts from the pool as a positive value) (\$)	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)		
OHINY EPO	EPO	EPO	EPO	01/01/2015	SG-All Others	EPO	Yes	Closed	53,732	332,511	XX	01/01/13	12/31/13	3,745,489	1,772,935,789	1,909,671,531	1,476,531,409	1,481,412,423	0	10,820,431	193,080,468	XX
OHINY SB	Direct	Direct	PPO	01/01/2015	SG-All Others	PPO	Yes	Closed	12,858	74,218	XX	01/01/13	12/31/13	885,655	472,563,248	502,910,647	409,395,949	405,411,667	0	2,558,590	51,464,206	XX
OHINY SB	Metro	Metro	PPO	01/01/2015	SG-All Others	PPO	Yes	Closed	7,755	42,241	XX	01/01/13	12/31/13	556,496	398,079,317	434,171,814	331,700,882	317,252,383	0	1,607,674	43,352,580	XX
OHINY EPO	EPO	EPO	EPO	01/01/2015	SG-Sole P	EPO	Yes	Closed	6,462	11,149	XX	01/01/13	12/31/13	133,631	70,842,034	76,289,020	61,203,122	63,568,001	0	386,050	7,715,008	XX
OHINY SB	Direct	Direct	PPO	01/01/2015	SG-Sole P	PPO	Yes	Closed	3,521	6,536	XX	01/01/13	12/31/13	79,612	46,288,538	49,393,528	35,967,188	39,043,048	0	229,993	5,041,024	XX
OHINY SB	Metro	Metro	PPO	01/01/2015	SG-Sole P	PPO	Yes	Closed	22	759	XX	01/01/13	12/31/13	9,966	7,336,191	8,021,064	6,195,614	9,137,171	0	28,791	798,943	XX
Total									84,350	467,414	XX	01/01/13	12/31/13	5,410,849	2,768,045,117	2,980,457,604	2,320,994,165	2,315,824,693	0	15,631,529	301,452,230	XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX
											XX											XX

EXHIBIT 17: HISTORICAL CLAIM DATA BY POLICY FORMS INCLUDED IN RATE ADJUSTMENT FILING

First Prior Experience Period (NY statewide experience, base medical policy form + associated riders)										Second Prior Experience Period (NY statewide experience, base medical policy form + associated riders)												
15.1 Beginning date of the experience period (mm/dd/yy)	15.2 Ending Date of the experience period (mm/dd/yy)	15.3 Member months for experience period	15.4 Earned premiums for experience period (\$)	15.5 Standardized earned premiums for experience period (\$)	15.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts from the pool as a positive value) (\$)	15.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.1 Beginning date of the experience period (mm/dd/yy)	16.2 Ending Date of the experience period (mm/dd/yy)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from state or federal reinsurance or stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool or federal risk sharing pool (\$)	16.8 Adjustment to the incurred claims for the period due to receipts from state or federal reinsurance or stop loss pools (enter receipts from the pool as a negative value) (\$)	16.9 Adjustment to the incurred claims for the period due to payments to the Regulation 146 pool or the federal risk sharing pool (enter receipts from the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)			
XX	01/01/12	12/31/12	3,054,665	1,392,990,493	1,601,732,065	1,064,092,114	1,116,789,405	0	3,738,375	156,792,263	XX	01/01/11	12/31/11	2,154,929	982,390,359	1,204,307,744	762,841,003	777,784,450	0	4,252,051	126,844,931	XX
XX	01/01/12	12/31/12	901,125	454,414,656	513,905,980	357,314,451	360,052,189	0	1,102,819	49,301,000	XX	01/01/11	12/31/11	954,933	455,540,704	561,057,381	372,830,601	365,116,540	0	1,884,249	57,915,180	XX
XX	01/01/12	12/31/12	648,075	424,843,742	502,072,033	339,287,659	342,046,948	0	793,130	43,287,162	XX	01/01/11	12/31/11	728,326,000	447,887,270	566,132,319	367,607,084	361,602,895	0	1,437,114	53,171,827	XX
XX	01/01/12	12/31/12	126,407	62,312,171	71,709,739	47,004,322	49,401,284	0	154,700	7,013,735	XX	01/01/11	12/31/11	112,458,000	53,128,806	64,484,202	41,123,383	43,975,253	0	221,899	6,859,921	XX
XX	01/01/12	12/31/12	81,746	44,398,585	50,234,903	32,593,261	34,699,651	0	100,043	4,816,954	XX	01/01/11	12/31/11	75,360,000	36,406,499	44,628,418	25,968,607	27,959,902	0	148,698	4,628,541	XX
XX	01/01/12	12/31/12	12,096	8,174,736	9,752,676	6,087,944	9,321,115	0	14,803	832,921	XX	01/01/11	12/31/11	18,601,000	11,828,531	14,906,110	8,612,498	11,230,008	0	36,703	1,404,248	XX
XX	01/01/12	12/31/12	4,824,114	2,387,134,383	2,749,407,397	1,846,379,750	1,912,310,592	0	5,903,870	262,044,036	XX	01/01/11	12/31/11	4,044,607	1,987,182,170	2,455,516,174	1,578,983,176	1,587,669,048	0	7,980,715	250,824,647	XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX
XX											XX											XX

Exhibit 18 - Index Rate/Plan-Design Level Adjustment Worksheet

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLC-129581419
 Market Segment : Individual Off Exchange

Separate column for each plan design (on or off Exchange)

Line #	General	Separate column for each plan design (on or off Exchange)			
1	Product*	EPO	EPO	EPO	EPO
2	Product ID*	26420NY002	26420NY002	26420NY002	26420NY002
3	Metal Level (or catastrophic)*	Bronze	Silver	Gold	Platinum
4	AV Metal Value (HHS Calculator)*	62.0%	70.7%	79.0%	88.1%
5	AV Pricing Value (total, risk pool experience based)*	62.6%	72.7%	82.0%	91.0%
6	Plan Type*	EPO	EPO	EPO	EPO
7	Plan Name*	Oxford Individual Standard Gated EPO \$3,000	Oxford Individual Standard Gated EPO \$2,000	Oxford Individual Standard Gated EPO \$600	Oxford Individual Standard Gated EPO
8	HIOS Plan ID*	26420NY0020043	26420NY0020040	26420NY0020037	26420NY0020034
9	Exchange Plan?*	No	No	No	No

* This field should be the same as used in the Unified Rate Review Template, Worksheet 2

Experience Period Index Rate

10A	Incurred Claims [exc. Reg 146 & Stop Loss pools & federal risk sharing and reinsurance pools] for Latest Experience Period	\$ 2,161,348,155			
10B	Member-Months for Latest Experience Period	5,187,640			
10C	Average PMPM Incurred Claims [L10A/L10B] (Initial Index Rate Factor)	416.63			
11	Average Pricing Actuarial Value reflected in experience period	0.674			
12	AV Adjusted Experience Period Index Rate PMPM (L10C / L11)	618.46	618.46	618.46	618.46

7	Plan Name*	Oxford Individual Standard Gated EPO \$3,000	Oxford Individual Standard Gated EPO \$2,000	Oxford Individual Standard Gated EPO \$600	Oxford Individual Standard Gated EPO
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**Market Wide Adjustments to the AV
Adjusted Experience Period Index Rate**

13	Impact of adjusting experience period data to EHB benefit level	1.021			
14	Market wide adjustment for changes in provider network **	1.000			
15	Market wide adjustment for fee schedule changes **	1.000			
16	Market wide adjustment for utilization management changes **	1.000			
17	Market wide adjustment for impact on claim costs from quality improvement and cost containment initiatives **	1.000			
18	Post/Pre ACA: Impact on risk pool of changes in expected covered membership risk characteristics **	1.000			
19	Post ACA: Ratio Individual risk pool to Small Group risk pool [Indiv. Only]	1.214			
20	Adjustment for changes in distribution of risk pool membership by rating regions **	1.000			
21	Federal Risk Adjustment Program Impact (less than 1.00 to reflect a recovery)	0.949			
22	Federal Transitional Reinsurance Program Recovery (less than 1.00 to reflect a recovery)	0.926			
23	Impact of adjustments due to experience period claim data not being sufficiently credible	1.000			
24	Claim trend projection factor (midpoint of experience period to mid point of rate applicability period)	1.242			
25	Indiv Reg 146 Payback	0.999			
26	Other 2 (specify)	1.000			
27	Other 3 (specify)	1.000			
28	Impact of Market Wide Adjustments (product L13 through L27)	1.351	1.351	1.351	1.351

** Not Included in Claim Trend Adjustment

7	Plan Name*	Oxford Individual Standard Gated EPO \$3,000	Oxford Individual Standard Gated EPO \$2,000	Oxford Individual Standard Gated EPO \$600	Oxford Individual Standard Gated EPO
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Plan Level Adjustments

29	Pricing actuarial value (without induced demand factor) #	0.626	0.727	0.820	0.910
30	Pricing actuarial value (only the induced demand factor) #	0.778	0.801	0.840	0.895
31	Impact of provider network characteristics ##	0.976	0.976	0.976	0.976
32	Impact of delivery system characteristics ##	1.000	1.000	1.000	1.000
33	Impact of utilization management practices ##	0.968	0.968	0.968	0.968
34	Impact on claim costs from quality improvement and cost containment initiatives ##	1.000	1.000	1.000	1.000
35	Benefits in additional to EHB (greater than 1.00)	1.000	1.000	1.000	1.000
36	Administrative costs (excluding Exchange user fees and profits)	1.185	1.185	1.185	1.185
37	Profit/Contribution to surplus margins	1.028	1.028	1.028	1.028
38	Impact of eligibility categories (catastrophic plans only)	1.000	1.000	1.000	1.000
39	Addition of Out of Network Benefit Option (e.g., POS or PPO, if applicable)	1.000	1.000	1.000	1.000
40	Impact of Adjustment for NYS Stop Loss reimbursements on SG HNY	1.000	1.000	1.000	1.000
41	Pediatric Dental and Vision	1.009	1.008	1.007	1.006
42	Other 2 (specify)	1.000	1.000	1.000	1.000
43	Impact of Plan Level Adjustments (product L29 through L42)	0.566	0.675	0.798	0.942

Changes that affect an entire standard population as cost sharing changes, not based on health status, age, gender or occupation

Beyond what is reflected in Market Wide adjustments

44	TOTAL PROJECTED INDEX RATE PMPM = (L12 x L28 x L43)	472.65	564.24	667.02	787.31
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EXHIBIT 19 - SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES AND PROFIT MARGIN

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLG-129581419
 Market Segment: Individuals Off Exchange

- 1) Complete a separate ROW for Metal Level/Product
 - Information should be for all the benefits included in that plan design including any riders (medical, drugs, etc).
 - Enter in column 1 the Metal Tier level. Use the drop down menu.
 - Enter in column 2 the plan designation as to On/Off Plan and Std/Non Standard Plan. Use the drop down menu.
 - Enter in column 3 the Estimated Membership as of a recent date mm/dd/yyyy; enter the date in column heading.
 - Append additional rows to the end of the existing rows as needed. Only use the first tab for data entry.
- 2) The average claim trend is the average annualized claim trend that is used in the applicable rate adjustment filing to project the source data forward to the applicable rating period (eg 10.0%).
- 3) Enter the required information for the new rate period included in this rate adjustment filing. This refers to the various expense components and profit margin included in the requested rates and the average annual claim trend assumed.
- 4) Enter the corresponding information requested for the immediately prior rate and form filing. This refers to the various expense components in the requested rates submitted for the immediately prior rate and form filing and the average claim trend assumed. If there is no immediately prior rate and form filing, enter the data from the initial rate and form filing.
- 5) **ACA Fees** are to be entered in columns 6.5 and 16.5.
- 6) This exhibit must be submitted as an Excel file and as a PDF file.

		For the rate period included in this rate adjustment filing											For the rate period included in this rate adjustment filing							
1. Metal Level [drop down menu]	2. On/Off Exchange Designation and Standard/Non Std [drop down menu]	3. Estimated Membership as of 05/31/2014	4.1 Period assumed beginning date (mm/dd/yy)	4.2 Period assumed ending date (mm/dd/yy)	5. Average annual claim trend assumed	6.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	6.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	6.3 Commissions and broker fees - as a % of gross premium	6.4 Premium Taxes - as a % of gross premium	6.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	6.6 Other administrative expenses - as a % of gross premium	6.7 Subtotal columns 6.1 through 6.6	7. After tax underwriting margin (profit/contribu- tion to surplus) - as a % of gross premium	8. State income tax component - as a % of gross premium	8.1 State income tax rate assumed (eg 3%)	9. Federal income tax component - as a % of gross premium	9.1 Federal income tax rate assumed (eg 30%)	10. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	11. Subtotal columns 6.7 + 7 + 8 + 9 + 10	
Bronze	Off Std	926	XX 01/01/15	12/31/15	10.95%	1.33%	0.00%	1.49%	2.80%	2.82%	6.78%	15.22%	1.73%	0.10%	3.55%	0.91%	33.24%	0.00%	17.96%	XX
Silver	Off Std	1,778	XX 01/01/15	12/31/15	10.95%	1.33%	0.00%	1.49%	2.80%	2.82%	6.78%	15.22%	1.73%	0.10%	3.55%	0.91%	33.24%	0.00%	17.96%	XX
Gold	Off Std	1,463	XX 01/01/15	12/31/15	10.95%	1.33%	0.00%	1.49%	2.80%	2.82%	6.78%	15.22%	1.73%	0.10%	3.55%	0.91%	33.24%	0.00%	17.96%	XX
Platinum	Off Std	4,333	XX 01/01/15	12/31/15	10.95%	1.33%	0.00%	1.49%	2.80%	2.82%	6.78%	15.22%	1.73%	0.10%	3.55%	0.91%	33.24%	0.00%	17.96%	XX

EXHIBIT 19: SUMMARY OF AVERAGE CLAIM TREND AND ADMINISTRATIVE EXPENSES

	For the rate period included in the prior rate and form filing													For the rate period included in the prior rate and form filing						
1. Metal Level [drop down menu]	2. On/Off Exchange Designation and Standard/Non Std [drop down menu]	3. Estimated Membership as of 05/31/2014		14.1 Period assumed - beginning date (mm/dd/yy)	14.2 Period assumed - ending date (mm/dd/yy)	15. Average annual claim trend assumed	16.1 Regulatory authority licenses and fees, including New York State 332 assessment expenses - as a % of gross premium	16.2 Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplement Health Care Exhibit - as a % of gross premium	16.3 Commissions and broker fees - as a % of gross premium	16.4 Premium Taxes - as a % of gross premium	16.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessment) - as a % of gross premium	16.6 Other administrative expenses - as a % of gross premium	16.7 Subtotal columns 20.1 through 20.6	17 After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	18 State income tax component - as a % of gross premium	18.1 State income tax rate assumed (eg 3%)	19 Federal income tax component - as a % of gross premium	19.1 Federal income tax rate assumed (eg 30%)	20 Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	21 Subtotal columns 16.7 + 17 + 18 + 19 +20
Bronze	Off Std	926	XX	01/01/14	12/31/14	10.53%	0.90%	0.30%	0.55%	2.03%	3.18%	4.35%	11.31%	4.76%	0.03%	0.34%	2.58%	35.00%	0.00%	18.67%
Silver	Off Std	1,778	XX	01/01/14	12/31/14	10.53%	0.90%	0.30%	0.55%	2.03%	3.18%	4.35%	11.31%	4.76%	0.03%	0.34%	2.58%	35.00%	0.00%	18.67%
Gold	Off Std	1,463	XX	01/01/14	12/31/14	10.53%	0.90%	0.30%	0.55%	2.03%	3.18%	4.35%	11.31%	4.76%	0.03%	0.34%	2.58%	35.00%	0.00%	18.67%
Platinum	Off Std	4,333	XX	01/01/14	12/31/14	10.53%	0.90%	0.30%	0.55%	2.03%	3.18%	4.35%	11.31%	4.76%	0.03%	0.34%	2.58%	35.00%	0.00%	18.67%

EXHIBIT 20: HIOS ID MAPPING TO PRODUCT NAMES

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLC-129581419
 Market Segment: Individuals Off Exchange

- 1) This exhibit is to help DFS reconcile the 14 digit HIOS IDs used to the different plan designs and to reconcile the rate manual to the binder rate template.
- 2) The HIOS IDs should be without the variants after the hyphen.
- 3) Column 3: Enter Metal Level. Use drop down menu.
- 4) Column 4: Enter On/Off Plan Designation. Use drop down menu.
- 5) Column 5: Enter Standard/Non Standard Plan Designation. Use drop down menu.
- 6) Column 6: Enter coverage of children to 26th birthday (26) or to 30th birthday. Use drop down menu.
- 7) Column 7: Enter Yes/No for coverage of Domestic Partner. Use drop down menu.
- 8) Column 8: Enter Yes/No for coverage of Family Planning. Use drop down menu.
- 9) Column 9: Enter Yes/No for coverage of Embedded Pediatric Dental. Use drop down menu.
- 10) Column 10: Enter Yes/No for coverage of Out of Network Benefits [PPO or POS]. Use drop down menu.
- 11) Column 11: Indicate if the plan design includes benefits in addition to the EHB benefits (yes) or (no). Use drop down menu.
- 12) This exhibit must be submitted as an Excel and as PDF file.

1 HIOS ID	2 Rate Manual Plan Name	3 Metal Level	4 Exchange Plan? (on, off, both)	5 Standard Plan Design? (yes, no)	6 Limiting Child Age? (26 or 30)	7 Domestic Partner Coverage Included? (yes, no)	8 Family Planning Coverage? (included, excluded)	9 Pediatric Dental Coverage Included? (yes, no)	10. Out of Network Benefits? (yes, no)	11 Include Benefits in Addition to EHB? (yes, no)
26420NY0020034	Oxford Individual Standard Gated EPO	Platinum	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020033	Oxford Individual Standard Gated EPO	Platinum	OFF	YES	29	NO	INCLUDED	YES	NO	NO
26420NY0020035	Oxford Individual Standard Gated EPO	Platinum	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020037	Oxford Individual Standard Gated EPO \$600	Gold	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020036	Oxford Individual Standard Gated EPO \$600	Gold	OFF	YES	29	NO	INCLUDED	YES	NO	NO
26420NY0020038	Oxford Individual Standard Gated EPO \$600	Gold	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020040	Oxford Individual Standard Gated EPO \$2,000	Silver	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020039	Oxford Individual Standard Gated EPO \$2,000	Silver	OFF	YES	29	NO	INCLUDED	YES	NO	NO
26420NY0020041	Oxford Individual Standard Gated EPO \$2,000	Silver	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020043	Oxford Individual Standard Gated EPO \$3,000	Bronze	OFF	YES	26	NO	INCLUDED	YES	NO	NO
26420NY0020042	Oxford Individual Standard Gated EPO \$3,000	Bronze	OFF	YES	29	NO	INCLUDED	YES	NO	NO
26420NY0020044	Oxford Individual Standard Gated EPO \$3,000	Bronze	OFF	YES	26	NO	INCLUDED	YES	NO	NO

EXHIBIT 23: SUMMARY OF REQUESTED 2015 PREMIUM RATES

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLC-129581419
 Market Segment: Individuals Off Exchange

- 1) Purpose of this Exhibit is to summarize all Premium Rates for all Metal Levels and for all Regions.
- 2) Premium rates are Calendar Year 2015 premium rates for Individual Only on Individual Plans and First Quarter 2015 premium rates for Employee Only on Small Group Plans.
- 3) Premium rates are only for plans with the following benefit provisions:
 - (a) Through Age 29; **and**
 - (b) With Domestic Partner; **and**
 - (c) With Family Planning.
- 4) This exhibit must be submitted as an Excel and as a PDF file.

SUMMARY OF REQUESTED 2015 PREMIUM RATES													
1. HIOS ID PLAN (14 Digits)	2. Metal Level or Catastrophic	3. Exchange [Ind/Sml Grp]	4. On/Off Exchange	5. Plan Type [Std or Non Std]	6. Pediatric Dental [Yes/No]	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
						Albany	Buffalo	Mid-Hudson	New York	Rochester	Syracuse	Utica	Long Island
26420NY0020033	Platinum	Individual	Off	Standard	Yes	n/a	n/a	1,222	1,222	n/a	n/a	n/a	1,222
26420NY0020036	Gold	Individual	Off	Standard	Yes	n/a	n/a	1,035	1,035	n/a	n/a	n/a	1,035
26420NY0020039	Silver	Individual	Off	Standard	Yes	n/a	n/a	876	876	n/a	n/a	n/a	876
26420NY0020042	Bronze	Individual	Off	Standard	Yes	n/a	n/a	734	734	n/a	n/a	n/a	734



<Date>

<Subscriber First Name> <Subscriber Last Name>

<Address 1>

<Address 2>

<City>, <State> <Zip>

Re: Notice of Proposed Premium Rate Change

<Plan Name>

Dear <Subscriber First Name> <Subscriber Last Name>:

Oxford Health Plans (NY), Inc. (OHPNY) is filing a request with the New York State Department of Financial Services (DFS) to approve a change to your premium rates for 2015. New York Insurance Law requires that we provide a notice to you when we submit requests for premium rate changes to DFS.

DFS is required by law to review our requested rate change. DFS may approve, modify or disapprove the requested rate change.

Proposed Premium Rate Change

The requested percentage change to your premium is shown in the attached exhibit. Please use the plan name listed above to reference the rate increase for your plan.

If you enrolled through the NY State of Health, the state's health plan marketplace, and you qualified for financial assistance, called an Advanced Premium Tax Credit, your current premium is less than the amount shown above and your 2015 premium will be less than shown above if you qualify for the APTC again next year. NY State of Health will calculate your eligibility for financial assistance each year.

Please note that while we try to provide you with the most accurate information possible, the final rate may differ based on the benefit plan design and other features you select on renewal. Also, the final, approved rate may differ because DFS may modify the proposed rate.

Why We Are Requesting a Rate Change

The main reason for the requested rate changes is due to a decrease in the projected Individual market cost level. However, medical expenses continue to increase. A number of factors contribute to these rising costs, including increases in the cost of medical services and increases in the amount of services used. We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment. This summary will be posted both on our website and DFS's website for at least 30 days from the date of our rate filing. Our rate application will be posted on DFS's website and additional information will be available on companyprofiles.healthcare.gov.

30-day Comment Period

You can contact us or DFS to ask for more information or submit comments to DFS about the proposed rate changes. The comments must be made within 30 days from the date of this notice.

You can contact OHPNY for additional information at:

Oxford
NY Prior Approval
P.O. Box 862
Monroe, CT 06468
800-767-3840
www.oxfordhealth.com

Comments or requests for more information on the proposed rate change may be submitted to:

NYS Department of Financial Services
Health Bureau – Premium Rate Adjustments
1 State Street
New York, NY, 10004
Email: premiumrateincreases@dfs.ny.gov
DFS Website: www.dfs.ny.gov/healthinsurancepremiums

If you choose to submit comments to DFS, please include the following information:

1. The name of your insurer
2. The name of your plan
3. Whether you have individual or group coverage
4. Your Plan Name, which is <Plan Name>

Written comments submitted to DFS will be posted on the DFS website with all your personal information removed.

Plain English Summary of Rate Change

We have prepared a plain-English summary that provides a more detailed explanation of the reasons why a premium rate change is being requested. You can find this information at the following websites:

Oxford website: www.oxfordhealth.com Go to the *Member Messages* section.

DFS website: www.dfs.ny.gov/healthinsurancepremiums

Notice of Approved Premium Rate

After DFS approves the final premium rate, you will receive final rate information at least 60 days before your 2015 renewal date.

Sincerely,



Howard C. Margolies
Vice President
Small Business, New York



Oxford Health Plans (NY), Inc. - Individual Off Exchange

Plan Name	Annual Requested Increase	
	Dep Age 26	Dep Age 29
Platinum		
Adult Gated Liberty NY Platinum	1.2%	1.2%
ChildOnly Gated Liberty NY Platinum	1.2%	1.2%
Adult Gated Liberty NY Platinum POS	1.2%	1.2%
ChildOnly Gated Liberty NY Platinum POS	1.2%	1.2%
Gold		
Adult Gated Liberty NY Gold	1.2%	1.2%
ChildOnly Gated Liberty NY Gold	1.2%	1.2%
Silver		
Adult Gated Liberty NY Silver	1.2%	1.2%
ChildOnly Gated Liberty NY Silver	1.2%	1.2%
Bronze		
Adult Gated Liberty NY Bronze	-0.6%	-0.6%
ChildOnly Gated Liberty NY Bronze	-0.6%	-0.6%

SYS_DateCurrent

SYS_Name
SYS_Add2
SYS_Add3 SYS_Add4
SYS_Add5, SYS_Add6 SYS_Zip

RE: Member_ID

Dear SYS_Name,

Renewal_Date marks your anniversary with Oxford as well as the time to renew your coverage. Simply remit your payment, as usual, upon receipt of your bill, but please be aware that **your annual renewal is the only opportunity you have to switch to a different Oxford plan.** You will notice that your bill has been updated to reflect the Renewal_Date New York renewal rates that are filed with the New York State Department of Financial Services.

	Current	Renewal
Individual	<u>CURRENT IN</u>	<u>Individual Rate</u>
Parent/Child	<u>CURRENT P</u>	<u>Parent Child Rat</u>
Husband/Wife	<u>CURRENT H</u>	<u>Husband Wife</u>
Family	<u>CURRENT F</u>	<u>Family Rate</u>

The new rates reflect the significant increase in healthcare costs in our area. If you have any questions about renewing your coverage with Oxford, please contact a Service Associate 1-800-767-3840. We will be happy to assist you.

Sincerely,

Oxford Health Plans®

New York
Group_ID CSP_Cd

Renewal_Date

Federal Rate Filing Justification Part III
Actuarial Memorandum & Certification
For Oxford Health Plans (NY), Inc.

State of New York Rate Review

General Information

Purpose: The purpose of this actuarial memorandum is to provide information relevant to the Part I Uniform Rate Review Template (URRT).

Company Identifying Information:

- **Company Legal Name:** Oxford Health Plans (NY), Inc.
- **State:** New York
- **HIOS Issuer ID:** 26420
- **Market:** Individual
- **Effective Date:** 1/1/2015 – 12/31/2015

Company Contact Information:

- **Primary Contact Name:** [REDACTED]
- **Primary Contact Telephone Number:** [REDACTED]
- **Primary Contact Email Address:** [REDACTED]

Proposed Rate Increase

Oxford Health Plans (NY), Inc. ("OHP") is filing rates for benefit plans written under existing policy forms and new certificates of coverage that comply with the requirements of the Patient Protection and Affordable Care Act (PPACA). The average requested annual rate increase is 1.1%.

Reasons for Rate Increase

The rate filing we have made is seeking a change mainly related to a decrease in the projected Individual market cost level. However, medical expenses continue to increase. Medical costs are the single largest component of the premium dollar and a component that has been rising significantly year over year. There are many different medical, or health care, cost trends that contribute to increases in the overall U.S. health care spending each year. These trend factors affect health insurance premiums, which will mean a premium increase to cover costs.

Experience Period Premiums and Claims

- **Experience Period:** There is no experience period data to report because this is a new product.
- **Premiums (net of MLR Rebate) in Experience Period:** There is no experience period data to report because this is a new product.
- **Allowed and Incurred Claims Incurred During the Experience Period:** There is no experience period data to report because this is a new product.

Benefit Categories

There is no experience period data to report because this is a new product.

Projection Factors

Projection factors were not used since there are no experience period claims to project for this new product.

Credibility

Because the Individual Off-Exchange product is new, we have no claims experience to project forward in the development of the rates. At the direction of the New York State Department of Financial Services ("DFS"), we adjusted the index rate for Oxford Health Insurance, Inc. ("OHI") small group by a morbidity adjustment to calculate the Individual rates. The development of the OHI small group index PMPM is described in the Part III Actuarial Memorandum for the OHI Small Group Filing (HIOS ID 85629). Based upon the statewide Individual enrollment data distributed by DFS, we determined that the age/sex factor for the 2014 Individual enrollees is 15.6% higher than the factor for statewide 2014 Small Group enrollees. Please note that we used NY OHI Large Group filed age/sex factors in this calculation. In addition to this actual demographic difference, we are estimating that the morbidity of the Individual enrollees is 5% higher than Small Group morbidity. Combining the impacts of demographics and morbidity since we cannot rate by age in New York, we expect the Individual cost level to be 21.4% higher than the Small Group cost level in 2015.

Paid to Allowed Ratio

We have developed the average paid to allowed factor for the projection period based upon an estimated distribution of Individual business in 2015 by metal level and the pricing actuarial values for those new plans.

Risk Adjustment and Reinsurance

- **Projected Risk Adjustments:** We have assumed a risk transfer factor of 1.000 for the Individual Off-Exchange product since it will be new and the expected cost is based upon an adjustment to the Small Group claims experience which has already been normalized to the statewide average risk level. The projected difference between the Individual and Small Group risk levels is reflected in the morbidity adjustment described above.
- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium:** We have assumed a payment of \$3.32 PMPM for the reinsurance fee. We have estimated that we will receive 7.4% of claims through the reinsurance program. We developed this estimate by trending the member level claims for OHP and OHI small group, Healthy NY, and Individual to 2015 and then running the trended claims through the federal reinsurance formula.

Non-Benefit Expenses and Risk Margin

Proprietary & Confidential

The 8.3% administrative expense load includes general administration (6.8%) and broker commissions (1.5%). We have estimated the expenses included in the development of the proposed rates based upon financial projections.

Projected Profit & Risk Margin

The projected profit and risk margin is 2.9% before state and federal income taxes and 1.7% after.

Taxes and Fees

The 7.9% includes state premium tax and assessments (3.2%), PPACA Insurer fee (3.2%), and state and federal income taxes (1.4%). This excludes the \$3.32 PMPM reinsurance fee.

Projected Loss Ratio

The projected loss ratio using federally prescribed MLR methodology is 88.2%.

Index Rate

There is no index rate for the experience period because this is a new product. The projected index rate of \$636.53 was calculated by applying the Individual morbidity adjustment to the 1st quarter 2015 OHI index rate.

AV Metal Values

AV metal values were calculated by DFS.

AV Pricing Values

The AV pricing values in Worksheet 2 reflect the product of plan relativities from the proprietary UnitedHealthcare pricing model, utilization adjustments, gatekeeper adjustments, and network adjustments. The relativities from the UnitedHealthcare model reflect the cost sharing differences between plans and do not include any adjustments for health status or utilization. The utilization adjustments were also determined by the proprietary UnitedHealthcare pricing model and only reflect utilization differences due to the levels of cost sharing. For the gatekeeper adjustment, we have assumed factors of 1.0 for non-gatekeeper and 0.96 for gatekeeper. For the network differences, we have assumed factors of 1.0 for Freedom and 0.97 for Liberty. The OHP Off – Exchange plans will be on the Liberty network. These adjustments do not reflect any differences in anticipated risk status. Please note that the gatekeeper and network factors apply to in-network medical claims only.

Membership Projections

Proprietary & Confidential

We are projecting 110,244 Individual Off-Exchange member months in 2015 which reflects an average of 9,187 members per month. These were estimated in collaboration with our finance and sales teams.

Terminated Products

Not applicable.

Plan Type

Not applicable.

Warning Alerts

Not applicable.

Reliance

Not applicable.

Actuarial Certification

I, [REDACTED], am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries.

I certify that the projected index rate is:

- a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- b. Developed in compliance with the applicable Actuarial Standards of Practice,
- c. Reasonable in relation to the benefits provided and the population anticipated to be covered, and
- d. Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

I qualify my opinion to state that the Part I Unified Rate Review Template does not demonstrate the process used by UnitedHealthcare to develop the rates. This process is

Proprietary & Confidential

described in detail in my state submitted actuarial memorandum. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for federally facilitated exchanges and for certification that the index rate is developed in accordance with Federal regulation and used consistently and only adjusted by the allowable modifiers.

Sincerely,

[Redacted signature block]

EXHIBIT 11: GENERAL INFORMATION ABOUT THE RATE APPLICATION

Company Name: Oxford Health Plans (NY), Inc.
NAIC Code: 95479
SERFF Tracking #: UHLC-129581419
Market Segment: Individuals Off Exchange

A. Insurer Information: Oxford Health Plans (NY), Inc. HMO - 44 For Profit 95479
Company submitting the rate adjustment request Company Type Org. Type Company NAIC Code
48 Monroe Turnpike, Trumbull, CT 06611
Company mailing address

B. Contact Person: [REDACTED] [REDACTED] [REDACTED]
Rate filing contact person name, title Contact phone number Contact Email address

C. Actuarial Contact (If different from above): _____
Actuary name, title Actuary phone number Actuary Email address

D. New Rate Information: February 15, 2015 through November 14, 2016 1/1/2015 UHLC-129581419
New rate applicability period New rate effective date SERFF Tracking Number

E. Market segment included in filing (e.g., Small Group (including Healthy NY Small Group), Individual - only one market segment per rate adjustment filing): Individual

Provide responses for the following questions:	Response
1. Does this filing include any revision to contract language that is not yet approved? See note (1). If yes, provide a brief description of the contract language changes included in this filing.	<u>Yes, This filing contains revised Certificate of Coverage, Rider and Schedule of Benefit documents that will be used for plans effective on or after 1/1/15. The revised forms utilize the model language provided by NY DFS. That model language was updated for use in 2015 so all forms will be updated accordingly.</u>
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing? If yes, mention these filings on Exhibit 18.	<u>No</u>
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (2).	<u>No, they will be mailed June 18th, 2014 per John Powell's approval</u>
4. Have all the required exhibits been submitted with this rate application? If any exhibit is not applicable, has an explanation been provided why such exhibit is not applicable?	<u>Yes, all the required exhibits have been submitted with this rate application</u>
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefiling.	<u>Yes, UHLC-129575078</u>

Notes:

- (1) As mentioned in the checklist, this combined non-grandfathered product rate adjustment and form/rate filing can only include minor contract revisions, such as due to changes in the model language, changes to the catastrophic plan due to change in out of pocket maximum, changes to the standard plan designs. Substantial changes need to be submitted as a separate form and rate filing (e.g., a new plan design not replacing an existing plan design, contract language changes not just due to changes in the model language).
- (2) §3231(e)(1) and §4308(c) of the New York Insurance Law require that the initial notice to policyholders/subscribers/contract holders be sent on or before the date the rate adjustment application is submitted to the Department of Financial Services.

EXHIBIT 21A

EXHIBIT 21A: HOSPITAL UNIT COST DEVELOPMENT - INPATIENT SERVICES

Company Name: Oxford Health Plans (NY), Inc.
 NAIC Code: 95479
 SERFF Number: UHLC-129581419
 Market Segment: Individuals Off Exchange

- 1) This exhibit shows a history of fee schedule increases by hospital for **INPATIENT services**.
- 2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
- 3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
- 4) Enter the Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital inpatient services.
- 5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
- 6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
- 7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
- 8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
- 9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
- 10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
- 11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	4. 2013 Small Groups Allowed Charges	5. % Change for Rate Year	6. % Change for Prior Year	7. % Change for Second Prior Year
107845	133957095	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
1859162	111562701	NORTH SHORE-LIJ HEALTH SYSTEM				
695425	131624096	MT SINAI HEALTH SYSTEM				
138790	133971298	NYU HEALTH SYSTEM				
2404659	131624082	MEMORIAL SLOAN KETTERING CANCER CTR				
393029	131624135	HOSPITAL FOR SPECIAL SURGERY				
582188	131624070	NORTH SHORE-LIJ HEALTH SYSTEM				
258249	133964321	WESTCHESTER MEDICAL CENTER				
278661	112241326	NORTH SHORE-LIJ HEALTH SYSTEM				
403442	112050523	LONG ISLAND HEALTH NETWORK				
520815	111633486	LONG ISLAND HEALTH NETWORK				
244193	113243405	STONY BROOK UNIVERSITY HOSPITAL				
212175	135564934	MT SINAI HEALTH SYSTEM				
683437	131740114	MONTEFIORE MEDICAL CENTER				
1140889	132997301	MT SINAI HEALTH SYSTEM				
70337	111635081	MAIMONIDES MEDICAL CENTER				
460334	131740130	WHITE PLAINS HOSPITAL CENTER				
152458	111630914	NORTH SHORE-LIJ HEALTH SYSTEM				
11085	112868878	NORTH SHORE-LIJ HEALTH SYSTEM				
445166	131740118	NORTHERN WESTCHESTER HOSP CTR				
727841	111667761	NORTH SHORE-LIJ HEALTH SYSTEM				
561679	111631796	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
718631	111888924	LONG ISLAND HEALTH NETWORK				
540098	111352310	LONG ISLAND HEALTH NETWORK				
450454	111839362	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
282392	111639818	LONG ISLAND HEALTH NETWORK				
135916	131740110	LAWRENCE HOSPITAL				
314422	132655001	NEW YORK CITY HEALTH AND HOSPITALS CORPOR				
461400	113241243	NORTH SHORE-LIJ HEALTH SYSTEM				
1952964	061562701	LONG ISLAND HEALTH NETWORK				
		TOTAL				



June 13, 2014

[REDACTED]
New York State Department of Financial Services
Health Bureau
25 Beaver Street
New York, NY 10004

RE: Oxford Health Plans (NY), Inc.
NY Individual Off-Exchange
Effective January 2015 – December 2015

Dear [REDACTED]

This rate filing addresses the development of the New York Individual Off-Exchange rates for plans written by Oxford Health Plans (NY), Inc. The rates are effective from January 2015 to December 2015.

Should you have any questions or need any additional information, please contact me at [REDACTED]
[REDACTED]

Sincerely,

[REDACTED]

EXHIBIT 21B: HOSPITAL UNIT COST DEVELOPMENT - OUTPATIENT SERVICES

Company Name: Oxford Health Plans (NY), Inc.
NAIC Code: 95479
SERFF Number: UHLC-129581419
Market Segment: Individuals Off Exchange

- 1) This exhibit shows a history of fee schedule increases by hospital for **OUTPATIENT services**.
- 2) Enter in column 1 the provider number for the hospital, in column 2 the provider tax ID, and in column 3 the provider name.
- 3) Enter in column 4 the allowed charges by hospital over a recent 12 month period which will be used as the hospital weights.
- 4) Enter in Small Group Market allowed charges for calendar year 2013; Charges should be only be for hospital outpatient services.
- 5) Enter in column 5 the actual or estimated percentage fee increase for that hospital over the proposed rate period (2015 over 2014).
- 6) Enter in column 6 the actual or estimated percentage fee increase for that hospital for the year immediately preceding the rate period (2014 over 2013).
- 7) Enter in column 7 the actual or estimated percentage fee increase for that hospital for the second year immediately preceding the rate period (2013 over 2012).
- 8) At the end, add a total row and show the sum of the weights and the weighted average of columns 5, 6, and 7.
- 9) The provider list need not include all hospitals but must include data for the hospitals comprising 90% of the New York State total allowed charges for the Small Group Market in calendar year 2013 used to develop the weights.
- 10) A redacted version of this exhibit can be created for posting on the DFS website as part of posting the rate adjustment submission.
- 11) This exhibit must be submitted as an Excel and as a PDF file.

1. Provider Number	2. Provider Tax ID	3. Provider Name	4. 2013 Small Groups Allowed Charges	5. % Change for Rate Year	6. % Change for Prior Year	7. % Change for Second Prior Year
138790	133971298	NYU HEALTH SYSTEM				
2404659	131624082	MEMORIAL SLOAN KETTERING CANCER CTR				
107845	133957095	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
1859162	111562701	NORTH SHORE-LIJ HEALTH SYSTEM				
393029	131624135	HOSPITAL FOR SPECIAL SURGERY				
695425	131624096	MT SINAI HEALTH SYSTEM				
278661	112241326	NORTH SHORE-LIJ HEALTH SYSTEM				
520815	111633486	LONG ISLAND HEALTH NETWORK				
683437	131740114	MONTEFIORE MEDICAL CENTER				
582188	131624070	NORTH SHORE-LIJ HEALTH SYSTEM				
403442	112050523	LONG ISLAND HEALTH NETWORK				
460334	131740130	WHITE PLAINS HOSPITAL CENTER				
445166	131740118	NORTHERN WESTCHESTER HOSP CTR				
212175	135564934	MT SINAI HEALTH SYSTEM				
244193	113243405	STONY BROOK UNIVERSITY HOSPITAL				
540098	111352310	LONG ISLAND HEALTH NETWORK				
88434	111667765	SOUTHAMPTON HOSPITAL				
406997	131725076	PHELPS MEMORIAL HOSPITAL CTR				
718631	111888924	LONG ISLAND HEALTH NETWORK				
282392	111639818	LONG ISLAND HEALTH NETWORK				
152458	111630914	NORTH SHORE-LIJ HEALTH SYSTEM				
1140889	132997301	MT SINAI HEALTH SYSTEM				
135916	131740110	LAWRENCE HOSPITAL				
11085	112868878	NORTH SHORE-LIJ HEALTH SYSTEM				
391462	135562304	MT SINAI HEALTH SYSTEM				
727841	111667761	NORTH SHORE-LIJ HEALTH SYSTEM				
507541	131740120	HUDSON VALLEY HOSPITAL				
450454	111839362	NEW YORK PRESBYTERIAN HEALTH SYSTEM				
1952964	061562701	LONG ISLAND HEALTH NETWORK				
258249	133964321	WESTCHESTER MEDICAL CENTER				
70337	111635081	MAIMONIDES MEDICAL CENTER				
351952	111661359	EAST END HOSPITAL ALLIANCE				
		TOTAL				



Oxford Health Plans (NY), Inc.

New York Individual
Rates Effective January 1, 2015 – December 31, 2015

ACTUARIAL CERTIFICATION

I, [REDACTED], am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

To the best of my knowledge and based upon the information and data available to me, I certify that:

- (a) The submission is in compliance with all applicable laws and regulations of the State of New York;
- (b) The submission is in compliance with the appropriate Actuarial Standards of Practice (ASOP's) including:
 - ASOP No. 5, Incurred Health and Disability Claims
 - ASOP No. 8, Regulatory Filings for Health Plan Entities
 - ASOP No. 12, Risk Clarification
 - ASOP No. 23, Data Quality
 - ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/ Casualty Coverages
 - ASOP No. 41, Actuarial Communications
- (c) The expected loss ratio incorporated into the rate tables meets the minimum requirement of the State of New York;
- (d) The benefits are reasonable in relation to the premiums charged; and
- (e) The rates are not unfairly discriminatory.

[REDACTED]

June 13, 2014

UnitedHealthcare

1/1/11 - 12/31/11

2. Number of Services	3. Amounts of Allowed Charges	4. Average Membership	5. Average Allowed Charge [=3/2]	6. Utilization per Member [=2/4]	7. Allowed Charge per Member [=3/4]
[REDACTED]					

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	X	Y		
1	Unified Rate Review v2.0.2																								
2																									
3	Company Legal Name:	Oxford Health Plans (NY), Inc.										State:	NY												
4	HIOS Issuer ID:	26420										Market:	Individual												
5	Effective Date of Rate Change(s):	1/1/2015																							
6																									
7																									
8	Market Level Calculations (Same for all Plans)																								
9																									
10																									
11	Section I: Experience period data																								
12	Experience Period:	1/1/2013		to	12/31/2013																				
13		<u>Experience Period</u>																							
14		<u>Aggregate Amount</u>		<u>PMPM</u>	<u>% of Prem</u>																				
15	Premiums (net of MLR Rebate) in Experience Period:	\$1		\$1.00	100.00%																				
16	Incurred Claims in Experience Period	\$1		1.00	100.00%																				
17	Allowed Claims:	\$1		1.00	100.00%																				
18	Index Rate of Experience Period			\$1.00																					
19	Experience Period Member Months	1																							
20	Section II: Allowed Claims, PMPM basis																								
21		<u>Experience Period</u>				<u>Projection Period:</u> 1/1/2015 to 12/31/2015				Mid-point to Mid-point, Experience to Projection:										24 months					
22		<u>on Actual Experience Allowed</u>				<u>Adj't. from Experience to Annualized Trend</u>				<u>Projections, before credibility Adjustment</u>						<u>Credibility Manual</u>									
23	<u>Benefit Category</u>	<u>Utilization per Description</u>	<u>Utilization per 1,000</u>	<u>Average Cost/Service</u>	<u>PMPM</u>	<u>Pop'l risk</u>		<u>Factors</u>		<u>Utilization per 1,000</u>	<u>Average Cost/Service</u>	<u>PMPM</u>	<u>Utilization per 1,000</u>	<u>Average Cost/Service</u>	<u>PMPM</u>										
24	Inpatient Hospital	Days	12,000.00	\$1.00	\$1.00	Morbidity	Other	Cost	Util	12,000.00	\$1.00	\$1.00	327.00	\$4,921.17	\$134.10										
25	Outpatient Hospital	Services	0.00	0.00	0.00	1,000	1,000	1,000	1,000	0.00	0.00	0.00	6742.55	181.43	101.94										
26	Professional	Services	0.00	0.00	0.00	1,000	1,000	1,000	1,000	0.00	0.00	0.00	22242.73	108.72	201.53										
27	Other Medical	Services	0.00	0.00	0.00	1,000	1,000	1,000	1,000	0.00	0.00	0.00	6680.62	139.94	77.91										
28	Capitation	Services	0.00	0.00	0.00	1,000	1,000	1,000	1,000	0.00	0.00	0.00	734.19	153.86	9.41										
29	Prescription Drug	Prescriptions	0.00	0.00	0.00	1,000	1,000	1,000	1,000	0.00	0.00	0.00	10596.54	126.43	111.64										
30	Total				\$1.00							\$1.00			\$636.53										
31																									
32	Section III: Projected Experience:																								
33		Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)										0.00%					100.00%					<u>After Credibility</u>	<u>Projected Period Totals</u>		
34		Paid to Allowed Average Factor in Projection Period															0.808								
35		Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM															\$514.00					\$56,665,595			
36		Projected Risk Adjustments PMPM															26.16					2,884,466			
37		Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM															\$487.84					\$53,781,130			
38		Projected ACA reinsurance recoveries, net of rein prem, PMPM															32.78					3,613,512			
39		Projected Incurred Claims															\$455.06					\$50,167,618			
40		Administrative Expense Load															8.27%					45.82		5,051,377	
41		Profit & Risk Load															1.73%					9.60		1,058,146	
42		Taxes & Fees															7.86%					43.53		4,799,029	
43		Single Risk Pool Gross Premium Avg. Rate, PMPM																				\$554.01		\$61,076,170	
44		Index Rate for Projection Period																				\$636.53			
45		% increase over Experience Period																				55300.90%			
46		% Increase, annualized:																				2253.74%			
47		Projected Member Months																						110,244	
48																									
49	Information Not Releasable to the Public Unless Authorized by Law: This information has not been publically disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.																								
50																									

Product-Plan Data Collection

Company Legal Name:
 HIOS Issuer ID:
 Effective Date of Rate Change(s):

Oxford Health Plans (NY), Inc.
26420
1/1/2015

State: **NY**
 Market: **Individual**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product	POS	HMO			
Product ID:	26420NY003	26420NY002			
Metal:	Platinum	Bronze	Silver	Gold	Platinum
AV Metal Value	0.881	0.620	0.707	0.790	0.881
AV Pricing Value	0.910	0.626	0.727	0.820	0.910
Plan Type:	POS	HMO	HMO	HMO	HMO
Plan Name	Oxford Individual Standard Gated EPO (GF)	Oxford Individual Standard Gated EPO \$3,000	Oxford Individual Standard Gated EPO \$2,000	Oxford Individual Standard Gated EPO \$600	Oxford Individual Standard Gated EPO
Plan ID (Standard Component ID):	26420NY0030005	26420NY0020043	26420NY0020040	26420NY0020037	26420NY0020034
Exchange Plan?	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2	0.00%	0.00%			
Historical Rate Increase - Calendar Year - 1	0.00%	0.00%			
Historical Rate Increase - Calendar Year 0	0.00%	0.00%			
Effective Date of Proposed Rates	1/1/2015	1/1/2015	1/1/2015	1/1/2015	1/1/2015
Rate Change % (over prior filing)	1.22%	-0.57%	1.23%	1.19%	1.22%
Cum'tive Rate Change % (over 12 mos prior)	0.00%	0.00%	0.00%	0.00%	0.00%
Proj'd Per Rate Change % (over Exper. Period)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Threshold Rate Increase %	0.00%	0.00%			

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	26420NY0030005	26420NY0020043	26420NY0020040	26420NY0020037	26420NY0020034
Inpatient	#DIV/0!	\$2.01	-\$0.55	\$1.39	\$1.60	\$1.93
Outpatient	#DIV/0!	\$1.53	-\$0.42	\$1.06	\$1.22	\$1.47
Professional	#DIV/0!	\$3.02	-\$0.83	\$2.09	\$2.40	\$2.90
Prescription Drug	#DIV/0!	\$1.67	-\$0.46	\$1.16	\$1.33	\$1.60
Other	#DIV/0!	\$1.17	-\$0.32	\$0.81	\$0.93	\$1.12
Capitation	#DIV/0!	\$0.14	-\$0.04	\$0.10	\$0.11	\$0.14
Administration	#DIV/0!	\$0.33	-\$0.09	\$0.23	\$0.26	\$0.32
Taxes & Fees	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Risk & Profit Charge	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total Rate Increase	#DIV/0!	\$9.86	-\$2.72	\$6.84	\$7.86	\$9.47
Member Cost Share Increase	#DIV/0!	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Average Current Rate PMPM	\$663.68	\$848.62	\$475.38	\$557.40	\$659.17	\$777.84
Projected Member Months	110,244	22,048	22,049	22,049	22,049	22,049

Product-Plan Data Collection

Company Legal Name:
 HIOS Issuer ID:
 Effective Date of Rate Change(s):

Oxford Health Plans (NY), Inc.
26420
1/1/2015

State: **NY**
 Market: **Individual**

Product/Plan Level Calculations

Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	26420NY0030005	26420NY0020043	26420NY0020040	26420NY0020037	26420NY0020034
Average Rate PMPM	#DIV/0!					
Member Months	0					
Total Premium (TP)	\$0	\$0	\$0	\$0	\$0	\$0
EHB Percent of TP, [see instructions]	#DIV/0!					
state mandated benefits portion of TP that are other than EHB	#DIV/0!					
Other benefits portion of TP	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Total Allowed Claims (TAC)	\$0					
EHB Percent of TAC, [see instructions]	#DIV/0!					
state mandated benefits portion of TAC that are other than EHB	#DIV/0!					
Other benefits portion of TAC	#DIV/0!	100.00%	100.00%	100.00%	100.00%	100.00%
Allowed Claims which are not the issuer's obligation:	\$0					
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0	\$0	\$0	\$0	\$0
Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Incurred claims, payable with issuer funds	\$0	\$0	\$0	\$0	\$0	\$0
Net Amt of Rein	\$0.00					
Net Amt of Risk Adj	\$0.00					
Incurred Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

Plan ID (Standard Component ID):	Total	26420NY0030005	26420NY0020043	26420NY0020040	26420NY0020037	26420NY0020034
Plan Adjusted Index Rate	\$669.94	\$858.48	\$472.66	\$564.24	\$667.03	\$787.31
Member Months	110,244	22,048	22,049	22,049	22,049	22,049
Total Premium (TP)	\$73,856,884	\$18,927,770	\$10,421,576	\$12,440,931	\$14,707,264	\$17,359,344
EHB Percent of TP, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$17,034,753	\$3,868,982	\$3,096,933	\$3,184,998	\$3,335,616	\$3,548,223
EHB Percent of TAC, [see instructions]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	\$3,293,904	\$347,410	\$1,158,053	\$870,427	\$599,406	\$318,608
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0	\$0	\$0	\$0	\$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Incurred claims, payable with issuer funds	\$13,740,849	\$3,521,573	\$1,938,880	\$2,314,571	\$2,736,210	\$3,229,616
Net Amt of Rein	\$0					
Net Amt of Risk Adj	\$0					
Incurred Claims PMPM	\$124.64	\$159.72	\$87.94	\$104.97	\$124.10	\$146.47
Allowed Claims PMPM	\$154.52	\$175.48	\$140.46	\$144.45	\$151.28	\$160.92
EHB portion of Allowed Claims, PMPM	\$154.52	\$175.48	\$140.46	\$144.45	\$151.28	\$160.92