

SECTION II

How Your Coverage Works

A. Your Coverage Under this [Contract; Policy].

You have been enrolled in an Essential Plan. We will provide the benefits described in this [Contract; Policy] to You. You should keep this [Contract; Policy] 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; Policy] 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; Policy]; and
- Received while Your [Contract; Policy] 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 [and Urgent Care.]

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call [XXX; the number on Your ID card]; or
- Visit Our website [at XXX].

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

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

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

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in

response to Your telephone request for network status information about the Provider;
or

- We do not provide You with a written notice within one (1) business day of Your telephone request for network status information.

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

[E.] The Role of Primary Care Physicians.

[This [Contract; Policy] [has; does not have] a gatekeeper, usually known as a Primary Care Physician (“PCP”).] [This [Contract; Policy] requires that You select a Primary Care Physician “PCP.”] [Although You are encouraged to receive care from Your PCP,] You [do not] need a [written] Referral from a PCP before receiving [certain] Specialist care [from a Participating Provider].

{Drafting Note: For an open access HMO product or other products that requires a PCP selection but do not require referrals to access care, insert the first, second and third sentences, indicating in the first sentence that the product does not have a gatekeeper and in the third sentence that referrals are not required. For all other products, insert the first sentence and the third sentence with appropriate wording. Indicate in the third sentence whether the member needs a referral from a PCP before receiving specialist care. Insert the second sentence if a PCP selection is required as applicable. }

[

You may select any participating PCP who is available from the list of PCPs in the [Essential Plan] [insert name of network] Network. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this [Contract; Policy] for more information about designating a Specialist.] .] [To select a PCP, visit Our website at [XXX].] [If You do not select a PCP, We will assign one to You.]

{Drafting Note: Plans requiring the selection of a PCP must include the paragraph above. Insert the last two sentences as applicable.}

[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; Policy] when the services provided are related to specialty care.]

{Drafting Note: Insert the bracketed sentence above as applicable.}

{Drafting Note: Plans requiring a PCP gatekeeper must include the paragraph below beginning with “Your PCP is responsible for determining the most appropriate treatment for your health care needs.” If the plan requires a PCP gatekeeper, the plan must include the direct access to obstetric and gynecologic services, emergency services, pre-hospital emergency medical services, emergency ambulance transportation and, if

covered, maternal depression screening language below. Plans may include direct access to other services and may add or delete services (other than the required services) from the list.}

[F.] [Services Not Requiring a Referral from Your PCP.

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

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening;
- [Urgent Care;]
- [Chiropractic services;]
- [[Outpatient] mental health care;]
- [[Outpatient] substance abuse services;]
- [[Outpatient] Habilitation Services (physical therapy, occupational therapy or speech therapy);]
- [[Outpatient] Rehabilitation Services (physical therapy, occupational therapy or speech therapy);][Refractive eye exams from an optometrist;]
- [Diabetic eye exams from an ophthalmologist;]
- [Home health care;]
- [Diagnostic radiology services;]
- [Laboratory procedures;][and]
- [All other services from Participating Providers.]]

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; Policy] for the services that require a Referral.

{Drafting Note: Insert all the paragraphs in 2 below for HMO products and any other products that use a PCP. Insert the first two paragraphs for products that use a network of providers.}

[G.] [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; Provider] to make sure he or she is accepting new patients.

{Drafting Note: For HMO and gatekeeper insurance products, insert the bracketed language “prior to notifying us of the PCP you selected” from the first set of brackets and “PCP” from the second set of brackets. For all other

insurance products that use a network of providers, do not use the language “prior to notifying us of the PCP you selected” and remove references to PCP and insert “provider” from the second set of brackets.}

To see a Provider, call his or her office and tell the Provider that You are a [insert health plan name] 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.

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

{Drafting Note: Insert the bracketed language above as applicable.}

[You may change Your PCP by [XXX]. [This can be done [XXX].]]

{Drafting Note: Describe the process for changing a PCP in the first set of brackets. Insert a timeframe for changing a PCP in the second set of brackets if applicable.}

[You may change Your Specialist by [XXX]. [This can be done [XXX].]]

{Drafting Note: Insert the two sentences above as applicable. Describe the process for changing a specialist in the first set of brackets. Insert a timeframe for changing a specialist in the second set of brackets if applicable.}

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

H. Out-of-Network Services.

The services of Non-Participating Providers are not Covered except Emergency Services and Pre-Hospital Emergency Medical Services [and ambulance services] to treat Your Emergency Condition, or unless specifically Covered in this [Contract; Policy].

[I.] Services Subject to Preauthorization.

Our Preauthorization is [not] required before You receive certain Covered Services.

[You are responsible for requesting Preauthorization for the in-network services listed in the Schedule of Benefits section of this [Contract; Policy].] [Your [PCP; Participating

Provider] is responsible for requesting Preauthorization for in-network services listed in the Schedule of Benefits section of this [Contract; Policy]].]

{Drafting Note: Use the first bracketed sentence for PPO, non-gatekeeper EPO, or other coverage without a gatekeeper where the member is required to request preauthorization. Use the second bracketed sentence for HMO, gatekeeper EPO, or any other product where the obligation to request preauthorization is with the member's PCP or participating provider. Plans that place the obligation on the member's PCP or participating provider to obtain preauthorization (instead of the member) do not need to list the services for which the PCP or participating provider must obtain preauthorization in the schedule of benefits.}

{Drafting Note: The paragraphs in J below are optional. Omit all of the bracketed language below for HMO coverage without an out-of-network option, gatekeeper coverage, or any other product where the obligation to request preauthorization is on the member's PCP and not the member, unless inserting "Your Provider".}

[J.] [[Preauthorization] [/] [Notification] Procedure.

If You seek coverage for services that require [Preauthorization] [or] [notification], [You; Your Provider] must call Us [or Our vendor] at [XXX; the number on Your ID card].

[[You; Your Provider] must contact Us to request Preauthorization as follows:

- [At least [two (2) weeks] prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.]
{Drafting Note: Use two weeks or less than two weeks.}
- [At least [two (2) weeks] prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.]
{Drafting Note: Use two weeks or less than two weeks.}
- [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.]
{Drafting Note: Use three months or longer than three months. Use 48 hours or longer than 48 hours.}
- [Before air ambulance services are rendered for a non-Emergency Condition.]]

{Drafting Note: The notification paragraph below is optional}

[You must contact Us to provide notification as follows:

- [As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.]

- [If You are hospitalized in cases of an Emergency Condition, You must call Us within [48] hours after Your admission or as soon thereafter as reasonably possible.]]

{Drafting Note: Use 48 hours or longer than 48 hours.}

{Drafting Note: The paragraph below may be deleted for plans that only require notification.}

[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.]]

{Drafting Note: Paragraph K below is optional. Omit the bracketed preauthorization language below for HMO coverage without an out-of-network option, gatekeeper coverage, or any other product where the obligation to request preauthorization is on the member's PCP and not the member. The penalty amounts may not exceed the lesser of \$500/50%. This preauthorization penalty is the only member penalty that is permitted when the obligation to request preauthorization is on the member. Plans may not otherwise impose other member penalties or deny claims in their entirety for failure to seek preauthorization or provide notification.}}

[K.] [Failure to [Seek Preauthorization] [or] [Provide Notification].

If You fail to [seek Our Preauthorization] [or] [provide notification] for benefits subject to this section, We will pay an amount of \$[500] less than We would otherwise have paid for the care, or We will pay only [50]% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining [charges; cost for services]. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not [seek Our Preauthorization] [or] [provide notification]. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.]

[L.] Medical Management.

The benefits available to You under this [Contract; Policy] 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.

[M.] Medical Necessity.

We Cover benefits described in this [Contract; Policy] 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.]

{Drafting Note: Include the items the plan considers.}

Services will be deemed Medically Necessary only if:

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

{Drafting Note: Insert the medical necessity requirements above as applicable.}

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

[N.] Protection from Surprise Bills.

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

- For services performed by a non-participating Provider at a participating

Hospital or Ambulatory Surgical Center, when:

- A participating Provider is unavailable at the time the health care services are performed;
- A non-participating Provider performs services without Your knowledge; or
- Unforeseen medical issues or services arise at the time the health care services are performed.

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

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

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Cost-Sharing. The Non-Participating Provider may only bill You for Your Cost-Sharing. You can sign a form to notify Us and the Non-Participating Provider that You received a surprise bill. The Surprise Bill Certification Form is available at www.dfs.ny.gov or You can visit Our website at [XXX] for a copy of the form. You need to mail a copy of the form to Us at the address [on Our website; on Your ID card; for Surprise Bill Certification Form in the Important Telephone Numbers and Addresses paragraph below] and to Your Provider.

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

[O.] Delivery of Covered Services Using Telehealth.

If Your [Participating] Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. An insurer may subject the coverage of a service delivered via telehealth to co-payments and/or

coinsurance provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the [Contract; Policy] that are at least as favorable as those requirements for the same service when not delivered using telehealth. “Telehealth” means the use of electronic information and communication technologies by a [Participating] Provider to deliver Covered Services to You while Your location is different than Your Provider’s location.

{Drafting Note: Insert “participating” as applicable.}

{Drafting Note: Insert the paragraphs in N below as applicable.}

[P.] [[Care; Case; Disease] Management.

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care [through Our [care; case; disease] management program] that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this [Contract; Policy]. 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.]

[Q.] Important Telephone Numbers and Addresses.

- CLAIMS
[Insert address; Refer to the address on Your ID card]
(Submit claim forms to this address.)

XXXX@XXXX.XXX

(Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
[XXX-XXX-XXXX; Call the number on Your ID card]
- SURPRISE BILL CERTIFICATION FORM
[Insert address; Refer to the address on Your ID card]
(Submit surprise bill certification forms to this address.)
- [MEDICAL EMERGENCIES AND URGENT CARE]
[XXX-XXX-XXXX; Call the number on Your ID card]
[Monday – Friday, X:XX a.m. – X:XX p.m.]
[Evenings, Weekends and Holidays]
{Drafting Note: Plans may delete the medical emergency and urgent care telephone numbers if they do not require notification for emergency services or authorization for urgent care.}
- MEMBER SERVICES
[XXX-XXX-XXXX; Call the number on Your ID card]
(Member Services Representatives are available [Monday - Friday, X:XX a.m. – X:XX p.m.]
- [PREAUTHORIZATION]
[XXX-XXX-XXXX; Call the number on Your ID card]
- BEHAVIORAL HEALTH SERVICES]
[XXX-XXX-XXXX; Call the number on Your ID card]
- OUR WEBSITE
[XXX.XXX.XXX]