{Drafting Note: This cover page is required for the Essential Plan.}

This is Your

ESSENTIAL PLAN
[CONTRACT; POLICY]

Issued by

[insert health plan name]

[This is Your individual [Contract; Policy] for the Essential Plan coverage issued by [insert health plan name.] This [Contract; Policy], together with the attached Schedule of Benefits, applications and any amendment or rider amending the terms of this [Contract; Policy], constitute the entire agreement between You and Us.

You have the right to return this [Contract; Policy]. Examine it carefully. If You are not satisfied, You may return this [Contract; Policy] 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; Policy].

Renewability. The renewal date for this [Contract; Policy] is twelve months from the effective date of coverage. This [Contract; Policy] will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this [Contract; Policy] or by You upon 30 days' prior written notice to Us.

In-Network Benefits. This [Contract; Policy] only covers in-network benefits. To receive in-network benefits You must receive care exclusively from Participating Providers [in Our [XXX] Network] [or Our affiliate's [XXX] Network] [and Participating Pharmacies in Our [XXX] Network] [who are located within Our Service Area]. [Care Covered under this [Contract; Policy] (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; Policy], You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency [or urgent] Condition described in the Emergency Services and Urgent Care section of this [Contract; Policy].] Except for care for an Emergency [or urgent] Condition described in the Emergency Services and Urgent Care section of this [Contract; Policy], You will be responsible for paying the cost of all care that is provided by Non-Participating Providers.] *{Drafting Note: The bracketed primary care physician language may be included for EPO or HMO coverage.}*

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

This [Contract; Policy] is governed by the laws of New York State.

[Insert signature, name and title of company officer(s).]

{Drafting Note: The sentence below is optional.}
If You need foreign language assistance to understand this [Contract; Policy], You may call Us at [XXX; the number on Your ID card].

TABLE OF CONTENTS

SECTION I

Definitions

Defined terms will appear capitalized throughout this [Contract; Policy].

Acute: The onset of disease or injury, or a change in the Subscriber'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; Policy] 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.

[**Contract; Policy**]**:** This [Contract; Policy] issued by [insert health plan name], including the Schedule of Benefits and any attached riders.

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

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

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

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

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

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

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

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

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

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

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

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a national cancer center institute-designated cancer center licensed by the department of health within Our service area; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Federal Poverty Level (FPL): A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain program and benefits, including the Essential Plan, and are

updated on an annual basis.

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

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

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

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

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

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

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

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

Lawfully Present Immigrant: The term "lawfully present" includes immigrants who have:

- "Qualified non-citizen" immigration status without a waiting period
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigration visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals). To see a full list of eligible immigration statuses, please visit the web site at http://www.healthcare.gov/immigrants/immigration-status/ or call the NY State of Health at 1-855-355-5777.

Medically Necessary: See the How Your Coverage Works section of this [Contract; Policy] for the definition.

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

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

NY State of Health ("NYSOH"): The NY State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace for health insurance where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan.

Non-Participating Provider: A Provider who doesn't have a contract with Us [or another XXX plan] to provide health care services to You. The services of Non-Participating Providers are Covered only for Emergency Services [, Urgent Care] 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 Balance Billing charges or the cost of health care services We do not Cover.

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

Us.

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

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

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

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

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine or family practice Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this [Contract; Policy] that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for the Subscriber. [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; Policy] [or as otherwise authorized by Us,] a Referral will not be made to a Non-Participating Provider.] [A Referral is not required but is needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this [Contract; Policy].]
{Drafting Note: Insert the second, third and fourth sentences as applicable. Insert the reference to paper referral forms if the plan accepts paper referrals. The bracketed "or as otherwise authorized by us" language is optional. }

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; Policy] that describes the Copayments, Coinsurance, Out-of-Pocket Limits, [Preauthorization requirements,] [Referral requirements,] and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: [XXX]
{Drafting Note: Insert list of counties in the plan's service area.}

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; Policy] is issued. Whenever a Subscriber is required to provide a notice pursuant to a Grievance or Emergency Department admission or visit, "Subscriber" also means the Subscriber's designee.

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

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a [participating] Physician's office or Urgent Care Center.
{Drafting Note: Insert the bracketed language, as consistent with the urgent care benefit in the Emergency Services and Urgent Care section of this contract; policy.}

Urgent Care Center: A licensed Facility [(other than a Hospital)] that provides Urgent Care.
{Drafting Note: The bracketed language is optional.}

Us, We, Our: [Insert health plan name] and anyone to whom We legally delegate performance, on Our behalf, under this [Contract; Policy].

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 Subscriber.

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**] [***I***] [**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. 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]

SECTION III

Access to Care and Transitional Care

A. [**Referral**; **Authorization**] **to a Non-Participating Provider.**
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve [a Referral; an authorization] to an appropriate Non-Participating Provider. Your Participating Provider [or You] must request prior approval of the [Referral; authorization] to a specific Non-Participating Provider. Approvals of [Referrals; authorizations] to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the [Referral; authorization], all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event [a Referral; an authorization] is not approved, any services rendered by a Non-Participating Provider will not be Covered.
.
{Drafting Note: The bracketed "or you" in the second sentence may be inserted for coverage where the obligation to request preauthorization is on the member.}

{Drafting Note: Use the paragraph below for HMO and gatekeeper insurance products.}
[**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; authorization] 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.]

{Drafting Note: Use the paragraph below for HMO and gatekeeper insurance products.}
[**C.**] [**Standing** [**Referral; Authorization**] **to a Participating Specialist.**
If You need ongoing specialty care, You may receive a "standing [Referral; authorization]" to a Specialist who is a Participating Provider. This means that You will not need a new [Referral; authorization] 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; authorization]. Any [Referral; authorization] 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; authorization] 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; authorization] 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.]

{Drafting Note: Use the paragraph below for HMO and gatekeeper insurance products.}
[**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; an authorization] 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; an authorization]. Any [Referral; authorization] 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; an authorization] 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; an authorization] 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 continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

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

[**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; Policy] 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; Policy]. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this [Certificate; Contract; Policy] becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

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

B. Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as shown in the Schedule of Benefits section of this [Contract; Policy].

C. Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Cost-Sharing for a Plan Year in the Schedule of Benefits section of this [Contract; Policy], We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year.

[Cost-Sharing for out-of-network services, except for Emergency Services[,] [and] out-of-network services approved by Us as an in-network exception [and] [out-of-network dialysis] does not apply toward Your [In-Network] Out-of-Pocket Limit.] [The Preauthorization; notification penalty described in the How Your Coverage Works section of this [Contract; Policy] does not apply toward Your Out-of-Pocket Limit.] The Out-of-Pocket Limit runs on a Plan Year basis.

D. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this [Contract; Policy], before any applicable Copayment or Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

[The Allowed Amount will be the amount We have negotiated with the Participating Provider], or the amount approved by [XXX]] [, or the Participating Provider's charge] [, if less].]
{Drafting Note: The bracketed language is optional.}

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

[**1.**] **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.]

See the Emergency Services and Urgent Care Section of this [Contract; Policy] for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this [Contract; Policy] for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this [Contract; Policy].

{*Drafting Note: use the paragraph below for Essential Plans 1 and 2}*

You, the Subscriber to whom this [Contract; Policy] is issued, are covered under this [Contract; Policy]. You must live or reside in Our Service Area to be covered under this [Contract; Policy]. You must have a household income above 138% through 200% of the Federal Poverty Level. If You are enrolled in Medicare or Medicaid or affordable Employer Sponsored Health Insurance, You are not eligible to purchase this [Contract; Policy]. Also, if Your income is above 138% of the Federal Poverty Level, You are not eligible to purchase this [Contract; Policy] if You are under 19 years old, greater than 64 years old, or are pregnant.

{Drafting note: Use the paragraph below for Essential Plans 3 and 4}

[You, the Subscriber to whom this [Contract; Policy] is issued, are covered under this [Contract; Policy]. You must live or reside in Our Service Area to be covered under this [Contract; Policy]. You must have a household income of 138% or below and be a Lawfully Present Immigrant who is not eligible for Medicaid. If you are enrolled in Medicare or Medicaid or affordable Employer Sponsored Health Insurance, are under 21 years old, greater than 64 years old, or You are pregnant, You are not eligible to purchase this [Contract; Policy].

You must report changes that could affect your eligibility throughout the year, including whether You become pregnant. If you become pregnant while enrolled in this product, You become eligible to obtain Medicaid. We strongly encourage pregnant women to enroll in Medicaid to ensure that newborns have continuous coverage from their birth, as newborns are not covered under the Essential Plan. If You transition to Medicaid, Your newborn will automatically be enrolled in Medicaid from their birth without a gap in coverage. *{Drafting Note: Use 21 for lawfully present immigrants not eligible for Medicaid due to immigration status}*

B. Types of Coverage.

The only type of coverage offered under the Essential Plan is Individual coverage, which means only You are covered. If additional members of Your family are also covered under the Essential Plan, they will receive a separate [Contract; Policy].

C. Enrollment.

{Drafting Note: Use the language below for Essential Plans 1 &2}
You can enroll in this [Contract; Policy] during any time of the year. If the NYSOH receives Your selection on or before the 15th of any month, Your coverage will begin on

the 1st of the following month. If the NYSOH receives Your selection on or after the 16th of the month, Your coverage will begin on the 1st of the next successive month. For example, if You make a selection on January 16, Your coverage will begin on March 1. If the NYSOH receives Your selection on or before December 15, Your coverage will begin on January 1.

{Drafting Note: Use the language below for Essential Plans 3 & 4}
You can enroll under this [Contract; Policy] during any time of the year. If You are a new applicant for coverage through the NYSOH, Your coverage will begin on the first of the month that Your plan selection is made. For example, if the NYSOH receives your Essential Plan selection on February 18, coverage under the plan will begin on February 1. Any services you received between February 1 and February 18 will be covered by Us. If you had coverage through the NYSOH under a different program or plan and switch to an Essential Plan, Your coverage will begin on the 1st of the month following your plan selection. For example, if You select an Essential Plan on February 19th, Your coverage would begin March 1st.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

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, 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 [XXX; the number on Your ID card] or visit Our website [at XXX] 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. Adult Annual Physical Examinations. We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website [at XXX], or will be mailed to You upon request.

You are eligible for a physical examination once every calendar 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, 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.

B. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments or Coinsurance when provided in accordance with the recommendations of ACIP.

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

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

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

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

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

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

E. 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 this [Contract; Policy], patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including

management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments or Coinsurance [when provided by a Participating Provider].

We also Cover vasectomies [subject to Copayments or Coinsurance].

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

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

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

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

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

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

This benefit is not subject to Copayments, Deductibles or Coinsurance [when

provided by a Participating Provider].

H. National Diabetes Prevention Program (NDPP). We cover diabetes prevention services provided by CDC-recognized programs for individuals at risk of developing Type 2 diabetes. The benefit covers 22 group training sessions over the course of 12 months. You may be eligible for NDPP services if you have a recommendation by a physician or other licensed practitioner and You are at least 18 years old, not currently pregnant, are overweight and have not been previously diagnosed with Type 1 or Type 2 Diabetes, AND You meet one of the following:

- You have had a blood test result in the prediabetes range within the past year, OR
- You have previously been diagnosed with gestational diabetes, OR
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this [Contract; Policy] 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. *{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}*

A. Emergency Ambulance Transportation.

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

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

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

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the [[lesser of the] FAIR Health rate at the [80]th percentile [or the Provider's billed charges].]

{Drafting Note: If plans use a source for the usual and customary charge other than FAIR Health, the name of the source should be inserted in the brackets above. Plans should also provide an explanation of how that source is the usual and customary charge, in compliance with Insurance Law §§ 3216(i)(24), 3221(l)(15) and §4303(aa).

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

B. Non-Emergency Ambulance Transportation.

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

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

C. Limitations/Terms of Coverage.

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

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: Plans may not impose preauthorization requirements on emergency services}

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

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

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; Policy]] [and] [on Your ID card] within [48] hours of Your admission, or as soon as is reasonably possible.]
{Drafting Note: Include the sentence above if the plan requires notice. Use 48 hours or longer than 48 hours.}

[We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing [If Your medical condition permits Your transfer to a participating Hospital, We will notify You and [work with You to] arrange the transfer.] *{Drafting Note: The bracketed sentence regarding transfers above is required for HMO and gatekeeper EPO coverage, but is optional for PPO and POS, and non-gatekeeper EPO coverage.}*

[**3.**] **Payments Relating to Emergency Services Rendered.**
We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services.
We will pay a Non-Participating Provider [the amount We have negotiated with the Non-Participating Provider for the Emergency Service] [or] [an amount We have determined is reasonable for the Emergency Service] [or] [the Non-Participating Provider's charge]. [However, [the negotiated amount] [or] [the amount We determine is reasonable] will not exceed the Non-Participating Provider's charge.]
{Drafting Note: Insert the applicable option or options from the first sentence. The second sentence is optional and may be included.}

{Drafting Note: The paragraph below may be omitted if the plan pays the non-participating provider's charge in all cases.}
[If a dispute involving a payment for Emergency Services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the services.]

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

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. [Urgent Care is typically available after normal business hours, including evenings and weekends.] [If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.] **Urgent Care is Covered in** [**or out of**] **Our Service Area**.
{Drafting Note: The bracketed sentences are optional.}

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

2. **Out-of-Network.** [We Cover Urgent Care from a non-participating Urgent Care Center [or Physician][outside Our Service Area].] [However, You [must; should] obtain Preauthorization from Us. Please contact Us at [XXX; the number on Your ID card] and You will be provided with instructions.] [We are available 24 hours a day, seven (7) days a week to help You in urgent medical situations.]

   [We do not Cover Urgent Care from non-participating Urgent Care Centers [or Physicians] [in Our Service Area].]
   {Drafting Note: Plans are not required to cover out-of-network urgent care. Use the language in either the first paragraph or second paragraph, as applicable.}

[If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.]
{Drafting Note: Include the sentence above if the plan requires notification for emergency admissions.}

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

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

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

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

D. Chemotherapy and Immunotherapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this [Contract; Policy].

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") [or a Physician] 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; Policy].
{Drafting Note: Plans may insert "physician", but are not required to.}

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 [Contract; Policy].

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 [Contract; Policy] for non-investigational treatments provided in the clinical trial.

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

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

G. Dialysis.

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

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

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per 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.
{*Drafting Note: use the paragraph below for Essential Plans 1 and 2}*

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 condition, per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

{Drafting note: Use the paragraph below for Essential Plans 3 and 4}

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

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

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

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

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

and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

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

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

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

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

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova or sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

4. **Exclusions and Limitations.** We do not Cover:
    - In vitro fertilization
    - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
    - Costs associated with an ovum or sperm donor, including the donor's medical expenses;
    - Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;
    - Cryopreservation and storage of embryos;
    - Ovulation predictor kits;
    - Reversal of tubal ligations;
    - Reversal of vasectomies;
    - Costs for and relating to surrogate motherhood that are not otherwise Covered Services under this [Certificate; Contract; Policy];
    - Cloning; or
    - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

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

K. Infusion Therapy.

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

L. Interruption of Pregnancy.

We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. [We Cover elective abortions [for one (1) procedure per Member, per [calendar year; Plan Year].]]

{Drafting Note: With respect to elective abortions, plans must include the one procedure limit for the standard NYSOH plan and may provide coverage that is more favorable for non-standard NYSOH plans and plans offered outside the NYSOH. Coverage for elective abortions may be removed for any individual or group policy.}

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

[**N.**] **Maternity and Newborn Care.**
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this [Contract; Policy] for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of [renting] [or] [the purchase of] one (1) breast pump per pregnancy [or, if greater, one (1) per calendar year] for the duration of breast feeding [from a Participating Provider [or designated vendor]].

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

[**Specialist e-Consultations Program.** If Your Participating Provider is rendering primary care services to You, he or she may conduct an electronic consultation with a Specialist to help evaluate Your condition or diagnosis. The electronic consultation will be provided by a Participating Provider in Our consultation program who will be selected by Your Participating Provider in his or her clinical judgement. The electronic consultation will be at no cost to You.
Your Participating Provider may consider the information provided by the Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies such as secure web-based email, fax and/or exchange of electronic medical records. The results may be documented in an electronic health record.]
{Drafting Note: The bracketed paragraph above is optional.}

P. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this [Contract; Policy] 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.]
{Drafting Note: The bracketed language above is optional.}

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

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

R. Prescription Drugs for Use in the Office and Outpatient Facilities.
We Cover Prescription Drugs (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefitapplies when Your Provider orders the Prescription Drug and administers it to You.
When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this [Contract; Policy].

S. Rehabilitation Services.
{*Drafting Note: use the paragraphs below for Essential Plans 1 and 2}*

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 condition per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury;
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

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

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

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

{Drafting note: Use the paragraph below for Essential Plans 3 and 4}

We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

{Drafting Note: The retail health clinic benefit is optional for standard NYSOH plans, non-standard NYSOH plans and plans offered outside NYSOH. The last two bracketed sentences are optional.}

[[**T.**] **Retail Health Clinics.**
We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses. [Retail health clinics are not a replacement for your PCP. Your PCP should be your first choice for care and for regular visits.]]

U. 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].
   {Drafting Note: The bracketed language is optional.}

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.]]

   {Drafting Note: The bracketed language above is optional, but must be used for plans that require second opinions for surgery.}

[**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; approve] Covered Services supported by a majority of the Providers reviewing Your case.

V. 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.

{Drafting Note: Use the language below for plans that cover surgical procedures differently depending on whether the procedures are performed through the same incision or through different incisions.}

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

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount [and [50]% of the amount We would otherwise pay under this [Contract; Policy] for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure].
   {Drafting Note: The bracketed language is optional.}

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

{Drafting Note: Use the following language instead of the language in paragraphs 1 and 2 above for plans that cover the surgical procedure with the highest amount and 50% of the other procedures regardless of whether the procedures are through the same incision or through different incisions.}

[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.]

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

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

W. Reconstructive Breast Surgery.

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

X. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

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

{Drafting Note: The telemedicine program benefit is optional for standard NYSOH plans, non-standard NYSOH plans and plans offered outside NYSOH.}

[**Y.**] [**Telemedicine Program**.

In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers that participate in Our telemedicine program.

[Insert telemedicine program description]]
{Drafting Note: If the plan has a telemedicine program, insert a description of the program in the brackets above, including how members can access the program.}

[**Z.**] **Transplants.**

We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants [for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome].
{Drafting Note: The bracketed language above is optional.}

{Drafting Note: Insert the sentences below if applicable.}

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

We Cover the Hospital and medical expenses, including donor search fees, of the Subscriber -recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is covered by Us. We do not Cover the medicalexpenses of a non-covered individual acting as a donor for You if the non-covered individual'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; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

A. Diabetic Equipment, Supplies and Self-Management Education.

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

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets

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

[Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling [XXX; the number on Your ID card]. Our medical director will make all medical exception determinations.] [Diabetic equipment and supplies are limited to a 30-day supply up to a maximum of a 90-day supply when purchased at a pharmacy.]
{Drafting Note: The paragraph above is optional. However, insurers and HMOs initially moving to one manufacturer will need to describe to DOH how they are transitioning members who are using equipment and supplies from other manufacturers. In addition, insurers and HMOs will need to demonstrate to DOH that members will continue to have access to all diabetic equipment and supplies required by law. Insert the last bracketed sentence as applicable.}

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

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

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

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

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

[These items also require Preauthorization and will be reviewed for Medical Necessity.] For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this [Contract; Policy].]

{Drafting Note: Insert the paragraphs regarding step therapy for diabetic equipment and supplies as applicable for the standard NYSOH plan, non-standard NYSOH plans and plans offered outside the NYSOH.}

B. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

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

2. Braces.

We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is

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

C. Hearing Aids.

1. External Hearing Aids.

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

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

2. Cochlear Implants.

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

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

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

D. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is 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; or homemaker, caretaker, or respite care.

E. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this [Contract; Policy]. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this [Contract; Policy]. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

F. 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; Policy] [and are only Covered under the Vision Care section of this [Contract; Policy].

We do not Cover shoe inserts.

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

Coverage is for standard equipment only.

We Cover the cost of [one (1)] prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

A. Hospital Services.

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

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

The Cost-Sharing requirements in the Schedule of Benefits section of this [Contract; Policy] 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 that occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other

licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this [Contract; Policy].

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; Policy] and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this [Contract; Policy] that apply to home care benefits.

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

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

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

G. Habilitation Services.

{Drafting Note: Use the paragraph below for Essential Plans 1 and 2}

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

{Drafting Note: Use the paragraph below for Essential Plans 3 and 4}

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy.

H. Rehabilitation Services.
{Drafting Note: Use the paragraph below for Essential Plans 1 and 2}

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit applies to all therapies combined.

{Drafting Note: Use the paragraph below for Essential Plans 3 and 4}

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your illness or injury;
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 (6) months of the later to occur:

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

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

J. End of Life Care.

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

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

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

[**K.**] [**Centers of Excellence.**
Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover the following Services [only] when performed at Centers of Excellence:
[insert list of services]
[insert any plan specific language regarding the centers of excellence program]]

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

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.

[3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.]
{Drafting Note: The bracketed language above is optional.}

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008. *{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}*

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the [Diagnostic and Statistical Manual of Mental Disorders].
{Drafting Note: If using a source other than the Diagnostic and Statistical Manual of Mental Disorders for the definition of mental health condition, insert the name of the source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.}

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this [Contract; Policy]. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. [In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.]
    {Drafting Note: The bracketed language regarding facilities outside New York is optional.}

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

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 health conditions. We Cover [up to a total of 20] family counseling visits during a [Plan Year / calendar year]. Family counseling includes family counseling visits with the enrollee present and family counseling visits without the enrollee present. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed nurse practitioner; [a licensed mental health counselor;] [a licensed marriage and family therapist;] [a licensed psychoanalyst;];] or a professional corporation or a university faculty practice corporation thereof. [In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.] Outpatient services also include nutritional counseling to treat a mental health condition.
{Drafting Note: The bracketed language regarding the additional three years of experience for social workers may be omitted for plans offered outside the NYSOH that wish to provide coverage for the make available social worker benefit. The bracketed language regarding licensed mental health counselors may be included if plans include those providers in their networks. The bracketed language regarding facilities outside New York is optional.}

3. **Autism Spectrum Disorder.** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the

screening, diagnosis, or treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

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

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

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

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

measurement, and functional analysis of the relationship between environment and behavior.

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; Policy]. 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; Policy].

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; Policy].

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 New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this [Contract; Policy] 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 or Coinsurance provisions under this [Contract; Policy] for similar services. For example, any Copayment or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this [Contract; Policy] for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the [Diagnostic and Statistical Manual of Mental Disorders].
{Drafting Note: If using a source other than the Diagnostic and Statistical Manual of Mental Disorders for the definition of substance use disorder, insert the name of the source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.}

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

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

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission [or a national accreditation organization recognized by Us] as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of

alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

{Drafting Note: The bracketed language regarding the national accreditation organization is optional.}

SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- [On Our Formulary;] and
- Dispensed by a licensed pharmacy.
  {Drafting Note: Insert the formulary bullet for plans that use a closed formulary to list covered prescription drugs. The bullet may be omitted for plans with an open formulary.}

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.
  {Drafting Note: Osteoporosis devices should be covered as part of the prescription drug benefit; however, if the cost-sharing is more favorable under the durable medical equipment benefit, plans may delete the reference to devices.}
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's

disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this [Contract; Policy].
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.]

You may request a copy of Our Formulary. Our Formulary is also available on Our website [at XXX]. You may inquire if a specific drug is Covered under this [Contract; Policy] by contacting Us at [XXX; the number on Your ID card].

B. Refills.

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

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; Policy] when Covered Prescription Drugs are obtained from a retail, [or mail order], [or Designated] pharmacy.
   {Drafting Note: Include the bracketed language if mail order is available. Mail order may be offered in the Essential Plan but is not required}

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

   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;
   - The Prescription Drug Cost for that Prescription Drug; or

   (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 Cost-Sharing [upon receipt of a complete Prescription Drug claim form]. Contact Us at [XXX; the number on Your ID card] [or visit Our website [at XXX]] to request approval.]
{Drafting Note: The bracketed paragraph above is required for HMO and EPO coverage and optional for PPO coverage. Bracketed language within the paragraph (for example "written") is optional.}

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 or conditions that are included in this program:
   - [Age related macular edema;
   - Anemia, neutropenia, thrombocytopenia;
   - Contraceptives;
   - Cardiovascular
   - Crohn's disease;
   - Cystic fibrosis;
   - Cytomegalovirus;
   - Endocrine disorders/neurologic disorders such as infantile spasms;
   - Enzyme deficiencies/liposomal storage disorders;
   - Gaucher's disease;
   - Growth hormone;
   - Hemophilia;
   - Hepatitis B, hepatitis C;
   - Hereditary angioedema;
   - HIV/AIDS;
   - Immune deficiency;

- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis)
- Transplant;
- RSV prevention].]

{Drafting Note: Include if the plan uses Designated Pharmacies. Plans may add to or subtract from the list of drugs specified above.}

[**5.**] [**Designated Retail Pharmacy for Maintenance Drugs.** You may also fill Your Prescription Order for Maintenance Drugs for up to a 90-day supply at a Designated retail Pharmacy [after an initial 30-day supply] [, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply]. You are responsible for paying the lower of:

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

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

{Drafting Note: The bracketed language regarding the initial 30-day supply is optional. If used, the language regarding contraceptives must also be inserted.}

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

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

- [Asthma;
- Blood pressure;
- Contraceptives;
- Diabetes;
- High cholesterol].

You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website [at XXX] or by calling [XXX; the number on Your ID card]. The Maintenance Drug list is updated

periodically. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the maintenance list.]
{Drafting Note: Include if the plan uses designated retail pharmacies for maintenance drugs. Plans may add to or subtract from the list of drugs or conditions specified above.}

[6.] [Mail Order. Certain Prescription Drugs may be ordered through Our mail order pharmacy [after an initial 30-day supply [, with the exception of contraceptive drugs, devices, or products which are available for -a 12-month supply]]. [We will only Cover drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy.] 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.)
{Drafting Note: The bracketed language regarding the initial 30-day supply is optional. If used, the language regarding contraceptives must also be inserted. The bracketed sentences limiting coverage of restricted drugs to mail order pharmacies is optional.}

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three Refills). You [will; may] 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 Prescription Drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports, You may obtain Your first [two (2)] Prescription Order[s] at a retail Participating Pharmacy. After Your first [two (2)] Prescription Order[s], You must obtain these Prescription Drugs from Our mail order pharmacy [or You must opt out of obtaining Your Prescription Drugs from Our mail order pharmacy]. [You may opt out by visiting Our website [at XXX] or by calling [XXX; the number on Your ID card].] [You must opt out [on an annual basis] [for each different Prescription Drug].]]
{Drafting Note: The bracketed language regarding mail order drugs is optional.}

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] [and; or] [Our vendor] 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 XXX] or by calling [XXX; the number on Your ID card.
{Drafting Note: Mail order drug coverage is optional. If mail order drug coverage is provided, the above language must be used.}

[**7.**] **Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per [calendar year; Plan Year], or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our 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[or is being removed from Our Formulary], We will notify You at least 30 days before the change is effective. When such changes occur, Your Cost-Sharing may change. [You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this [Certificate; Contract; Policy]]. You may access the most up to date tier status on Our website [at XXX] or by calling [XXX; the number on Your ID card].
{Drafting Note: Insert the bracketed formulary removal provisions for plans with a closed formulary.}

[**8.**] **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, [You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned] [or] [the Brand-Name Drug will be removed from the Formulary and You no longer have benefits for that particular Brand-Name Drug]. Please note, if You are taking a Brand-Name Drug that is being [excluded] [or] [placed on a higher tier] due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this [Contract; Policy].]
{Drafting Note: Insert one or both of the bracketed provisions above as applicable. Insert the last bracketed sentence if brand-name drugs will be removed from the formulary.}

[**9.**] **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. [The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects.] If coverage is denied under Our standard or

expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this [Contract; Policy]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out more about this process.
{Drafting Note: The bracketed sentence is optional.}

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone [and in writing] no later than 72 hours after Our receipt of Your request. [We will notify You in writing within three (3) business days of receipt of Your request.] If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.
{Drafting Note: Plans should insert one of the two bracketed options regarding written notification.}

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-formulary Prescription Drug, You may request an expedited review of a Formulary exception. [The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process.] We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone [and in writing] no later than 24 hours after Our receipt of Your request. [We will notify You in writing within three (3) business days of receipt of Your request.] If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.
{Drafting Note: The bracketed sentence is optional. Also note, plans must make a decision within 24 hours even if a statement from the prescribing health care professional is not included with the request. Plans should insert one of the two bracketed options regarding written notification }

[**10.**] **Supply Limits.** [Except for contraceptive drugs, devices or products,] We will pay for no more than a [30; 90]-day supply of a Prescription Drug purchased at a retail pharmacy [or Designated Pharmacy]. You are responsible for [one (1) Cost-Sharing amount; up to three (3) Cost-Sharing amounts] for up to a [30; 90]-day supply. [However, for maintenance drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for [one (1) Cost-Sharing amount; up to three (3) Cost-Sharing amounts; one (1) Cost-Sharing amount for Prescription Drugs on tier 1 and three (3) Cost-Sharing amounts for Prescription Drugs on tier 2 and tier 3] for a 90-day supply at a retail pharmacy.]
{Drafting Note: Include the bracketed language if the Plan covers a 90-day

supply of maintenance drugs. Plans may insert one of the cost-sharing options from the brackets above.

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

[Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two (2); two and a half 2.5 Cost-Sharing amount[s] for a 90-day supply.]
{Drafting Note: Include the bracketed language if mail order is available.}

{Drafting Note: The bracketed language below is optional.}
[Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a [retail] [or] [mail order] pharmacy. You may access Our website [at XXX] or by calling [XXX; the number on Your ID card] for more information on supply limits for specialty Prescription Drugs.]

[Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website [at XXX] or by calling [XXX; the number on Your ID card]. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this [Contract; Policy].]
{Drafting Note: The language above is optional.}

[11.] [Initial Limited Supply of Prescription Opioid Drugs. If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be [the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.] [prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.]]
{Drafting Note: Plans should insert one of the bracketed provisions describing the copayments charged for the limited supply.}

[**12.**]**Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this [Contract; Policy].

[**13.**][**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 XXX] or by calling [XXX; the number on Your ID card].]

{Drafting Note: Insert if the plan has a half tablet program.}

[**14.**] [**Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes [or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill]. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get [up to] a 15-day supply [(or appropriate amount of medication needed for an average infertility treatment cycle)] of Your Prescription Order for certain drugs filled at a [Designated; retail; mail order] [P;p]harmacy instead of the full Prescription Order. You initially pay [half the 30-day Cost-Sharing; a lesser Cost-Sharing based on what is dispensed; no Cost-Sharing for the initial fill, and the second fill will have a full 30-day Cost-Sharing]. The therapeutic classes of Prescription Drugs that are included in this program are: [Antivirals/Anti-infectives, Infertility, Iron Toxicity, Mental/Neurologic Disorders, Multiple Sclerosis, and Oncology]. [With the exception of Infertility drugs,] [T;t]his program applies for the first 60 days when You start a new Prescription Drug. [For Infertility drugs, the program applies to Your infertility treatment cycle.] This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website [at XXX] or by calling [XXX; the number on Your ID card].]

{Drafting Note: Insert if the plan has a split fill program. The language in brackets for infertility drugs is optional. Plans may add to or subtract from the list of drugs or conditions specified above.}

D. [**Medical Management.**

This [Contract; Policy] 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.

{Drafting Note: The preauthorization paragraphs below are optional. If the preauthorization language is included, use one of the bracketed provisions in the second sentence of the first paragraph that explains how preauthorization works. Please note that the obligation to request preauthorization for prescription drugs is on the provider. In addition, include the first sentence in the second paragraph that explains how the member can determine which drugs require preauthorization.}

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, [We will contact Your Provider to determine if Preauthorization should be given] [ask Your Provider to complete a Preauthorization form] [Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug]. [Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.] Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

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

{Drafting Note: The step therapy paragraph below is optional.}

[**2.**] [**Step Therapy.** Step therapy is a process in which You may need to use one [or more] type[s] of Prescription Drug[s] before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this

[Contract; Policy].]

{Drafting Note: The therapeutic substitution paragraph below is optional.}

[**3.**] [**Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website [at XXX] or call [XXX; the number on Your ID card].]

[**E.**] [**Limitations/Terms of Coverage.**

{Drafting Note: The following limitations are permissible. A plan does not need to include all of the limitations. However, if a limitation is included, the language below must be used.}

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 [and prescribing Providers] may be limited. If this happens, We may require You to select a single Participating Pharmacy [and a single Provider] that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. [Benefits will be paid only if Your Prescription Orders or Refills are written by the selected Provider or a Provider authorized by Your selected Provider.]. If You do not make a selection within 31 days of the date We notify You, We will select a single .Participating Pharmacy [and/or prescribing Provider] for You.

3. Compounded Prescription Drugs will be Covered only when [they contain at least one (1) ingredient that; the primary ingredient] is a Covered legend Prescription Drug, [they are not essentially the same as a Prescription Drug from a manufacturer] and are obtained from a pharmacy that is approved for compounding. [All compounded Prescription Drugs [over [$250]] require [Your Provider to obtain] Preauthorization.] [Compounded Prescription Drugs are on tier [2;3].]

   {Drafting Note: HMOs and EPOs with a gatekeeper using the bracketed preauthorization language must use "Your Provider". Plans may require preauthorization for all compounded drugs or only those drugs over a set dollar limit. Plans may insert a dollar limit.}

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; Policy].

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; Policy].

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this [Contract; Policy]. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary, or as otherwise stated in this [Contract; Policy]. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. [We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.]
{Drafting Note: The bracketed language is optional.}

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; Policy].

11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.]

[**F.**] **General Conditions.**

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. [You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.]
{Drafting Note: Insert the bracketed language above as applicable.}

[**2. Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for Your coverage. We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. [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; may] change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.] [If a Prescription Drug is eligible for a rebate, most of the rebate will be used to reduce the Allowed Amount for the Prescription Drug. Your Deductible or Coinsurance is calculated using that reduced Allowed Amount. The remaining value of that rebate will be used to reduce costs for all Members enrolled in coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than Our estimate.]
{Drafting Note: The paragraph above is optional.}

[**G.**] **Definitions.**

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this [Contract; Policy]).

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; Policy]. This list is subject to Our periodic review and modification (no more than four (4) times per [calendar year; Plan Year] or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website [at XXX] or call [XXX; 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. [**Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.]
   {Drafting Note: Insert the definition of maintenance drug as applicable.}

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Subscribers. [We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.]
   {Drafting Note: Insert the bracketed language above as applicable.}

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   [A Participating Pharmacy can be either a retail or mail-order pharmacy.]
   {Drafting note: Include the bracketed sentence above if mail order is available.}

8. **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.
{Drafting Note: The bracketed language above is optional.}

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, [We have agreed to pay Our Participating Pharmacies; as contracted between Us and Our pharmacy benefit manager] for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your [Certificate; Contract; Policy] 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.
{Drafting Note: Insert the appropriate language from the brackets depending whether the plan contracts directly with participating pharmacies or with a pharmacy benefit manager.}

10. **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.

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

SECTION [XIV]

Wellness Benefits

{ The exercise facility reimbursement benefit may be substituted. Variable language in the exercise facility reimbursement benefit permits reimbursement for exercise facilities or classes.}

[**A. Exercise Facility Reimbursement.**
We will partially reimburse You for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities [that We have an agreement with and] which maintain equipment and programs that promote cardiovascular wellness. [We will also reimburse fees paid for exercise classes (e.g., yoga, pilates, spinning) [,including fees [or subscriptions] for online, virtual or live-streamed fitness classes].] [An eligible exercise facility must have at least [two (2)] pieces of equipment or activities that promote cardiovascular wellness from the following list:

- [Insert list of equipment or activities.]

{Drafting Note: The bracketed language regarding exercise classes is optional for all plans. The bracketed language regarding the list of equipment and activities is optional for all plans.}

Reimbursement is limited to actual workout visits [or online workouts]. We do not reimburse:

- Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;
- Lifetime memberships;
- Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.);
- Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.

In order to be eligible for reimbursement, You must:

- [Be an active member of the exercise facility [or] [attend classes at the exercise facility]; and]
- [Complete [50] visits [or online workouts] in a six (6)-month period.]

{Drafting Note: Plans should insert the applicable language for reimbursement eligibility.}

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

- [A completed reimbursement form; Documentation of the visits from the facility.] [Each time You visit the exercise facility, a facility representative must sign and date the [reimbursement form; documentation of the visits].]
- [A copy of Your current facility bill which shows the fee paid for Your [membership; classes].]
- [A copy of the [brochure] that outlines the services the exercise facility offers.]

{Drafting Note: Plans should insert the applicable language for obtaining reimbursement depending on the documentation required by the plan.}

Once We receive [the completed reimbursement form; documentation of the visits] [and] [the bill], You will be reimbursed the lesser of [$200] or the actual cost of the membership per six (6)-month period.] [Reimbursement must be requested within [120] days of the end of the six (6)-month period.] [Reimbursement will be issued only after You have completed each six (6)-month period even if [50] visits are completed sooner.]]
{Drafting Note: All plans may increase the dollar amount for the benefit or lower the required visit number. If plans insert the bracketed sentence beginning with "Reimbursement must be requested", plans must use no less than 120 days.}

[**B. [Wellness Program].**
{Drafting Note: Plans may insert a name other than "Wellness Program".}
1. Purpose.
The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.

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

- [A health risk assessment tool]
- [A designated smoking cessation program]
- [A designated weight management program]
- [A designated stress management program]
- [A designated worker injury prevention program]
- [A designated health or fitness incentive program]
- [Health or fitness center membership]
- [Designated online wellness activities]
- [Designated healthy activities]
- [Self-management of chronic diseases]

{Drafting Note: All wellness programs must have a nexus to health insurance and the details of the wellness program must be specified in the certificate; contract; policy. Plans must provide a more detailed description of the wellness program for each applicable bullet above and may add additional bullets.}

3. **Eligibility.**
You, the Subscriber, can participate in the wellness program.

4. Participation.
The preferred method for accessing the wellness program is through Our website [at XXX]. You need to have access to a device with internet access in order to participate in the website program. However, if You do not have internet access, please call Us at [XXX; the number on Your ID card] and We will provide You with information regarding how to participate without internet access.

5. Rewards.

Rewards for participation in a wellness program include:

- [Full or partial reimbursement of the cost of participating in smoking cessation or weight management programs.]
- [Full or partial reimbursement of the cost of membership in a health club or fitness center.]
- [The waiver or reduction of Copayments, Deductibles or Coinsurance.]
- [Contributions to a health reimbursement account ("HRA") or health savings account ("HSA").]
- [Monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.]
- [Merchandise, so long as the item is geared at promoting good health, such as healthy cookbooks or nutritional or exercise equipment.]]

{Drafting Note: The rewards for wellness programs must have a nexus to health insurance and the details of the wellness program must be specified in the; contract; policy. Plans must provide a more detailed description of the wellness program for each applicable bullet above and may add additional bullets. Contracts; policies that are required to be community-rated may not include a discounted premium rate or a rebate or refund of premium as a reward. Contracts; policies that are experience-rated which involve a discounted premium rate or a rebate or refund of premium shall be based on an actuarial demonstration that the wellness program can be reasonably expected to result in the overall good health and well-being of the group.}

SECTION XV

Vision Care

{Drafting Note: Effective June 1, 2021, Section XV is required for Essential Plans 1 and 2 (e.g., those whose income is above 138% through 200% FPL)}}

Please refer to the Schedule of Benefits section of this [Contract; Policy] for day or visit limits and any Preauthorization or Referral requirements that apply to these benefits. *{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}*

A. Vision Care.
We Cover emergency, preventive and routine vision care.

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

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

C. Prescribed Lenses and Frames.
We Cover standard prescription lenses or contact lenses one (1) time [in any 12-month period; per Plan Year, per calendar year], unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. [If You choose non-standard lenses, We will pay the amount that We would have paid for standard lenses and You will be responsible for the difference in cost between the standard lenses and the non-standard lenses.] [The difference in cost does not apply toward Your Out-of-Pocket Limit.]

We also Cover standard frames adequate to hold lenses one (1) time [in any 12-month period; per Plan Year; per calendar year], unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply

toward Your Out-of-Pocket Limit.

[**D**. **How to Access Vision Services.**
If You need to find a Participating Provider or change Your Provider, please call [XXX; the number on Your ID card] or visit Our website at [XXX].]

SECTION XVI

Dental Care

{Drafting Note: Effective June 1, 2021, use Section XVI for Essential Plan 1 and Essential Plan 2 products (e.g., those whose income is above 138% through 200% FPL).}

Please refer to the Schedule of Benefits section of this [Contract; Policy] for day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. *{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}*

We Cover the following dental care services:

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; two (2) times per Plan Year].

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); two (2) times per Plan Year];
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing Ix-rays at six (6) to 12-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation; and
- Amalgam, composite restorations and stainless-steel crowns.

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 limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics [or cosmetic orthodontics] that are otherwise Covered under this [Certificate; Contract; Policy].

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.

We do not Cover implants or implant related services.

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 complement 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. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics [or cosmetic orthodontics] that are otherwise Covered under this [Certificate; Contract; Policy].

H. 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).

[

I. How to Access Dental Services. If You need to find a dentist or change Your dentist, please call [name of Dental Vendor] at [insert number and days/times] or please call Us at [insert number and days/times]. Customer Service Representatives are there to help You. Many speak Your language or have services that will translate in any language You need.]

SECTION [XVII]

ADDITIONAL BENEFITS FOR CERTAIN ESSENTIAL PLAN SUBSCRIBERS

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents. Use this section only for Essential Plan 3 and Essential Plan 4 products (e.g., those whose income is at or below 138% of FPL)}

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

A. Dental Services

1. Covered Dental Services. We Cover regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

2. How to Access Dental Services. If You need to find a dentist or change your dentist, please call [name of Dental Vendor] at [insert number and days/times] or please call Us at [insert number and days/times]. Customer Service Representatives are there to help You. Many speak Your language or have services that will translate in any language You need.

3. Orthodontia Services. Orthodontia is Covered when You have a Medically Necessary surgical treatment, such as reconstructive surgery of your jaw.

4. Prosthodontics. Full and /or partial dentures are Covered when they are required to alleviate a serious health condition or one that affects employability. This service requires Preauthorization. Complete dentures and partial dentures whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight years from initial placement except when determined Medically Necessary by Us. Preauthorization requests for replacement dentures prior to eight years must include a letter from Your Physician and dentist. The letter from Your dentist must explain the specific circumstances that necessitates replacement of the denture. The letter from Your Physician must explain how dentures would alleviate Your serious health condition or improve Your employability. If replacement dentures are requested within the eight year period after they have already been replaced once, then supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

5. Implant Services. Dental implants will be Covered when Medically Necessary. Preauthorization requests for implants must have supporting documentation from Your Physician and dentist. The letter from Your Physician must explain how

implants will alleviate the medical condition. The letter from Your dentist must explain why other Covered functional alternatives for prosthetic replacement will not correct Your dental condition and why You require implants. Other supporting documentation for the request may be submitted including x-rays.

B. Vision Services.

1. Covered Vision Services. [We offer vision care through a contract with (name of Vendor), an expert in providing high quality vision services.] We Cover the following vision services:

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a Participating Provider;
- Eye exams, generally every 12 months, unless medically needed more often
- Low-vision exam and vision aids ordered by Your doctor
- Specialist referrals for eye diseases or defects.

2. How to Access Vision Services. If You need to find a vision Provider or change Your vision Provider, please call [name of Vendor] at [insert number] or please call Us at [insert number and days/times].

C. Non-prescription Drugs (Over-the-Counter or OTC)

In addition to the Prescription Drug Coverage described in Section [], We also Cover non-prescription (OTC) drugs, medical supplies, and hearing aid batteries when ordered by a licensed Provider.

D. Foot Care Services

We Cover routine foot care provided by licensed Provider types when Your physical condition poses a hazard due to the localized presence of an illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise Covered Services such as the diagnosis and treatment of diabetes, ulcers and infections. We do not Cover routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, cleaning or soaking feet, unless You have a pathological conditions that requires the services.

E. Orthopedic Footwear

We Cover orthopedic footwear when used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the

ankle or foot, or to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. Coverage includes shoes, shoe modifications or shoe additions. We do not Cover sneakers and athletic shoes.

F. Family Planning Services

In addition the Family Planning Services described in Section [], You may receive certain Family Planning and Reproductive Health services either from one of Our Participating Providers or from any appropriate Medicaid health Provider of Your choice. You do not need a referral from your PCP to obtain these services. If You visit any appropriate Medicaid health Provider, the cost to You will be the same as the cost of seeing on of Our Participating Providers.

The following are the Family Planning and Reproductive Health services that You may receive from any Medicaid health Provider or a Participating Provider:

1. Screening, related diagnosis, ambulatory treatment, and referrals to a Participating Provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormalities.

2. Screening, related diagnosis, and referral to Participating Provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.

3. HIV testing and pre-test and post-test counseling when performed as part of a Family Planning visit.

You must visit a Participating Provider in order to have the following Family Planning and Reproductive Health services covered by Us:

1. Infertility Treatment as set forth in the Family Planning Services described in Section [].

2. Routine gynecologic care, including hysterectomies, as set forth in Outpatient Services Section of this [Contract; Policy].

3. Any other Family Planning and Reproductive Health Services not specified above.

G. Non-Emergency Transportation

In addition to the non-emergency ambulance transportation benefit in Section [], You are eligible for non-emergency transportation, which includes personal vehicle, bus, taxi, ambulette, and public transportation to medical appointments. You or Your Provider must call the vendor listed below to arrange transportation:

NYC (all boroughs): Medical Answering Services - 1-844-666-6270
Long Island (Nassau and Suffolk): Logisticare - 1-844-678-1103
All other counties: Medical Answering Services – see below:

{Drafting note: if plan service area includes counties outside of New York City and Long Island, list the individual counties within plan service area and corresponding phone number from Medical Answering Services' website at https://www.medanswering.com/locations/nys/ .]

You can access this information online at: https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_PA_Guidelines_Contact_List.pdf

If possible, You or Your Provider should call the vendor at least three days before Your medical appointment and provide Your appointment date and time, its address, and the doctor You are seeing.

H. Family Counseling

If You are receiving, or in need of, treatment for a substance use disorder, We cover outpatient family counseling visits.

SECTION [XVIII]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents. The following exclusions are permissible except for Conversion Therapy, which must be included in the exclusions. A plan does not need to include all of the exclusions. However, if an exclusion is included, the language below must be used for individual, small group and large group coverage.}

Exclusions and Limitations

No coverage is available under this [Contract; Policy] for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.
We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this [Contract; Policy]. 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; Policy] unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover orthodontia services except as specifically stated in the Dental Care section of this [Contract; Policy]

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

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

I. Foot Care.
We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as stated in section XVII of this [Contract; Policy]. 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. *{Drafting note: insert the applicable section number for the Additional Benefits for Certain Essential Plan members}*

J. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law [unless You are taken to the Hospital because it is close to the place where You were

injured or became ill and Emergency Services are provided to treat Your Emergency Condition].
{Drafting Note: The bracketed language above is optional.}

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

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

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

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

O. Services Not Listed.
We do not Cover services that are not listed in this [Contract; Policy] as being Covered.

P. Services Provided by a Family Member.
We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

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

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

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

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

SECTION [XIX]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents. This section is required.}

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this [Contract; Policy]. Either You or the Provider must file a claim form with Us. If the 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 [XXX; the number on Your ID card] [or visiting Our website [at XXX]]. Completed claim forms should be sent to the address [in the How Your Coverage Works section of this [Contract; Policy]] [or] [on Your ID card]. You may also submit a claim to Us electronically by [sending it to the e-mail address [in the How Your Coverage Works section of this [Contract; Policy]; on Your ID card]] [or] [visiting Our website [at XXX]].

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within [120 days; 180 days; 12 months; 15 months, 18 months] after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the [120-day; 180-day; 12-month; 18-month] period, You must submit it as soon as reasonably possible. [In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.]
{Drafting Note: The time to file a claim must be a minimum of 120 days. Plans may insert a number greater than 120 days. Commercial insurers (insurers subject to Article 32 of the New York Insurance Law) may insert the last sentence for individual policies.}

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

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim

determination procedure applies to contractual benefit denials [and Referrals]. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this [Contract; Policy].
{Drafting Note: Plans may insert "Referrals" as applicable.}

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; Policy].

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.
{Drafting Note: Plans may insert "referral" as applicable.}

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

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

G. Post-Service Claim Determinations.

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

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H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION [XX]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.
}

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 [XXX; the number on Your ID card]] [, in person,] [or] in writing to file a Grievance. [You must use Our Grievance form for written Grievances.] [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.

{Drafting Note: Plans must permit insureds to submit an oral grievance in connection with a denial of a referral or a covered benefit determination*. Plans are not required to accept oral grievances in other instances. Plans may require insureds to use their grievance form for the submission of written grievances.}*

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

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

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

C. Grievance Determination.

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

Expedited/Urgent Grievances: By phone, within the earlier of 48 hours of

	receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A Claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within [30 calendar days of receipt of Your Grievance] [45 calendar days of receipt of all necessary information] [45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance]. *{Drafting Note: Plans must select one of the bracketed provisions.}*

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
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
E-mail: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov]
{Drafting Note: For use with HMO products.}

[**Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:**
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov]

SECTION [XXI]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.

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 [XXX or, for mental health and substance use disorder services, XXX; 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.

{Drafting Note: Insert the bracketed sentence regarding contact information for a behavioral health organization as applicable.}

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

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

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

B. Preauthorization Reviews.

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

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

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone [and in writing] within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. [Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.]
   {Drafting Note: If plans do not provide the written notification within 48 hours, delete the "and in writing" and insert the bracketed sentence beginning "Written notification will be provided the earlier of".}

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. [**Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make

a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.]
{Drafting Note: Include the paragraph above if preauthorization for inpatient rehabilitation services following a hospital discharge is required.}

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

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) [and Your Provider], by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) [and Your Provider], by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of [15 calendar days; one (1) business day] of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.
{Drafting Note: Plans may use 15 calendar days or one business day.}

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

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

3. [**Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) [and Your Provider], by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) [and Your Provider] within [72] hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.]
{Drafting Note: Include the paragraph above if authorization for home care following a hospital discharge is required.}

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

[5.] **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use the clinical review tool designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

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

D. Retrospective Reviews.
If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You [and Your Provider] within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You [and Your Provider] in writing within 15 calendar days of the earlier of Our receipt of 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. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request should include supporting rationale and documentation from a Health Care Professional, demonstrating that:
   - The required Prescription Drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
   - The required Prescription Drug is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;

- You have tried the required Prescription Drug while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a Prescription Drug selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
- The required Prescription Drug is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) [and Your Health Care Professional] within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) [and Your Health Care Professional] within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews)

of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.]

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

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

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

1. [**Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and

- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network [Referral; Authorization] Denial.** You also have the right to Appeal the denial of a request for [a Referral; an authorization] to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network [Referral; authorization] denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.]

I. [**First Level; 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 the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer

assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

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

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

[J.] Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

[**K.**] **Appeal Assistance.**
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org
{Drafting Note: For use with insurance products.}

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

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

SECTION [XXII]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.}

External Appeal

A. Your Right to an External Appeal.

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

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

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

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

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

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

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

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

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

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

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

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

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

E. Your Right to Appeal an Out-of-Network [Referral; Authorization] Denial to a Non-Participating Provider.

If We have denied coverage of a request for [a Referral; an authorization] to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

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

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

F. Your Right to Appeal a Formulary Exception Denial.

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this [Contract; Policy] for more information on the formulary exception process.]

G. The External Appeal Process.

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

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

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

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

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

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

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

{Drafting Note: The following language below should be used by plans opting to charge a fee for external appeals.}
[We will charge You a fee of [insert any amount up to $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.]

H. 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]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.}

Termination of Coverage

This [Contract; Policy] may be terminated as follows:

A. Automatic Termination of this [Contract; Policy].
This [Contract; Policy] shall automatically terminate

1. Upon Your death.

2. When You turn 65, Your coverage will end at the end of the month in which you turn 65 or become Medicare eligible, whichever is earlier.

3. When You become Medicaid eligible or enroll in the Medicaid Program, Your coverage will end at the end of the month in which you are determined to be Medicaid eligible.

4. When Your income exceeds 200% of the Federal Poverty Level, Your coverage will end at the end of the month in which your income has changed.

5. When You have had a change in immigration status that makes you eligible for other coverage, including Medicaid, and Your coverage will end at the end of the month before you are determined to be Medicaid eligible.

6. When You have enrolled in a different program through the NY State of Health Marketplace.

7. When you have enrolled in affordable Employer Sponsored Health Insurance.

B. Termination by You.
You may terminate this [Contract; Policy] at any time by giving the NYSOH at least 14 days' prior written notice.

C. Termination by Us.
We may terminate this [Contract; Policy] with 30 days' written notice as follows:

1. Fraud or Intentional Misrepresentation of Material Fact.
   If You 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, this [Contract; Policy] will terminate

immediately upon a written notice to You from the NYSOH. [However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application, We will rescind this [Contract; Policy] if the facts misrepresented would have led Us to refuse to issue this [Contract; Policy] and the application is attached to this [Contract; Policy]. Rescission means that the termination of Your coverage will have a retroactive effect of up to [one (1) year; the issuance of this [Contract; Policy]].] .
{Drafting Note: The language above related to rescission is optional.}

2. If You no longer live or reside in Our Service Area.

3. The date the [Contract; Policy] is terminated because We stop offering the class of [contracts; policies] to which this [Contract; Policy] belongs, without regard to claims experience or health related status of this [Contract; Policy]. We will provide You with at least 90 days prior written notice.

4. The date the [Contract; Policy] 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 You 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; Policy] for Your right to conversion to another individual [Contract; Policy].

SECTION [XXIV]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty.

Upon completion of active duty, Your coverage may be resumed as long as You make written application to Us.

For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION [XXV]

{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents.

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; Policy] does not require any Provider to accept a Subscriber as a patient. We do not guarantee a Subscriber's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this [Contract; Policy] [or legal claims based on a [denial of benefits] [or] [request for plan documents]] to any person, corporation or other organization. Any assignment of benefits [or legal claims based on a [denial of benefits] [or] [request for plan documents] by You will be void and unenforceable.]

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

{Drafting Note: If the legal claims language is used, insert the last bracketed sentence beginning with "Nothing in this paragraph…" }

3. Changes in this [Contract; Policy].
We may unilaterally change this [Contract; Policy] upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.
This [Contract; Policy] 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; Policy], or any other documentation issued by Us in connection with this [Contract; Policy], 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 [Contract; Policy] 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; Policy] may be limited to a specific number of visits. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, Your coverage terminates and you enroll in the product later in the year.

[**8.**] **Entire Agreement.**
This [Contract; Policy], including any endorsements, riders and the attached applications, if any, constitutes the entire [Contract; Policy].

{Drafting Note: Paragraph 9 below is optional.}
[**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.**
You will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this [Contract; Policy]. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

[**11.**] **Identification Cards.**
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this [Contract; Policy].

[**12.**] **Incontestability.**

No statement made by You in an application for coverage under this [Contract; Policy] shall avoid the [Contract; Policy] or be used in any legal proceeding unless the application or an exact copy is attached to this [Contract; Policy]. [After two (2) years from the date of issue of this [Contract; Policy], no misstatements, except for fraudulent misstatements made by You in the application for coverage, shall be used to void the [Contract; Policy] or deny a claim.]

{Drafting Note: Paragraph 13 below is optional.}
[**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 while receiving care from any Participating Provider or in any Participating Provider's Facility.

{Drafting Note: HMOs and coverage subject to Article 43 of the New York Insurance Law must include paragraph 14 below, and it should be used for other coverage, as applicable.}

[**14.**] [**Input in Developing Our Policies.**

You may participate in the development of Our policies by [XXX].]

{Drafting Note: Describe how subscribers may participate in the development of policies.}

[**15.**] **Material Accessibility.**

We will give You] ID cards [Contracts; Policies], riders and other necessary materials.

[**16.**] **More Information about Your Health Plan.**

You can request additional information about Your coverage under this [Contract; Policy]. 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 Subscriber information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this [Contract; Policy].
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the [Certificate; Contract; Policy].

[**17.**] **Notice.**

Any notice that We give You under this [Contract; Policy] 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: [XXX; the address on Your ID card].

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

[**19.**] **Renewal Date.**
The renewal date for this [Contract; Policy] is 12 months after the effective date of this [Contract; Policy]]. This [Contract; Policy] will automatically renew each year on the renewal date, as long as you remain eligible under the [Contract; Policy] and unless otherwise terminated by Us as permitted by this [Contract; Policy].

[**20.**] **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; Policy]. 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; Policy]. 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; Policy].

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

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

{Drafting Note: Paragraph 22 below is optional.}
[**22.**] [**Service Marks.**
[_____] is an independent corporation organized under the New York Insurance Law. [_____] also operates under licenses with [_____], licenses [_____] to use the [_____] service marks in a portion of New York State. [_____] does not act as an agent of the [_____]. [_____] is solely responsible for the obligations created under this agreement.]

[**23.**] **Severability.**
The unenforceability or invalidity of any provision of this [Contract; Policy] shall not affect the validity and enforceability of the remainder of this [Contract; Policy].

{Drafting Note: Paragraph 24 below is optional.}
[**24.**] [**Significant Change in Circumstances.**
If We are unable to arrange for Covered Services as provided under this [Contract; Policy] 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.]

{Drafting Note: The paragraphs in 25 below are optional.}
[**25.**] [**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; Policy]. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

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

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

[**26.**] **Third Party Beneficiaries.**
No third party beneficiaries are intended to be created by this [Contract; Policy] and nothing in this [Contract; Policy] 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; Policy]. No other party can enforce this [Contract; Policy]'s provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this [Contract; Policy], or to bring an action or pursuit for the breach of any terms of this [Contract; Policy].

[**27.**] **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; Policy]. You must start any lawsuit against Us under this [Contract; Policy] within [two (2); three (3)] years from the date the claim was required to be filed.
{Drafting Note: Use 3 years for individual commercial (Article 32) insurance contracts; policies. Use 2 years for all other contracts; policies.}

[**28.**] **Translation Services.**
Translation services are available free of charge under this [Contract; Policy] for non-English speaking Subscribers. Please contact Us at [XXX; the number on Your ID card] to access these services.

{Drafting Note: Paragraph 29 below is optional.}
[**29.**] [**Venue for Legal Action.**
If a dispute arises under this [Contract; Policy], 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.]

[**30.**] **Waiver.**
The waiver by any party of any breach of any provision of this [Contract; Policy] 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.

[**31.**] **Who May Change this** [**Contract; Policy**]**.**

This [Contract; Policy] may not be modified, amended, or changed, except in writing and signed by Our [Chief Executive Officer ("CEO"); Chief Operating Officer ("COO"); President] or a person designated by the [CEO; COO; President]. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this [Contract; Policy] 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; COO; President] or person designated by the [CEO; COO; President].

[**32.**] **Who Receives Payment under this** [**Contract; Policy**]**.**
Payments under this [Contract; Policy] 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. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this [Certificate; Contract; Policy] for more information about surprise bills.

[**33.**] **Workers' Compensation Not Affected.**
The coverage provided under this [Contract; Policy] is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

[**34.**] **Your Medical Records and Reports.**
In order to provide Your coverage under this [Contract; Policy], 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; Policy], except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

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

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, and other authorized federal, state and local agencies with authority over the Essential Plan, quality oversight organizations, and third parties with which We contract to assist Us in administering this [Contract; Policy], so long as they

also agree to maintain the information in accordance with state and federal confidentiality requirements. If You want to take away any permissions you gave to release this information, you may call us at [###].

{Drafting Note: HMOs must include paragraph 35 below and it should be used for other coverage as applicable. The bracketed language within paragraph 35 is optional }
[**35.**] [**Your Rights [and Responsibilities].**
[As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits.] You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

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

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

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

[You have the right to access Our Participating Providers.]

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

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

[For additional information regarding Your rights and responsibilities, visit the FAQs on Our website at [XXX]. If You do not have internet access, You can call Us at [XXX; the number on Your ID card] to request a copy.] If You need more information or would like to contact Us, please go to Our website at [XXX] call Us at [XXX; the number on Your ID card].]