

## 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. Diabetic Services**

If You are diagnosed with diabetes, You will not be responsible for Cost-Sharing for the following Covered Services.

- Primary care office visits for the diagnosis, management, and treatment of diabetes. However, Cost-Sharing may apply to other services provided during the same visit as the diabetic services. Also, if a diabetic service is provided during an office visit when the diabetic service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply;
- One office visit to perform an annual dilated retinal examination, including when performed by a Specialist;
- One office visit to perform an annual diabetic foot exam, including when performed by a Specialist;
- Laboratory procedures and tests for the diagnosis and management of diabetes.

#### **H. 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.

## **I. Habilitation Services.**

*{Drafting Note: use the paragraph below for Essential Plans 1, 2, and 200-250}*

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.

## **J. 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:

- a. Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- b. Part-time or intermittent services of a home health aide;
- c. Physical, occupational or speech therapy provided by the Home Health Agency; and
- d. 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.

## **K. 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.

**L. 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.

**M. Interruption of Pregnancy.**

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

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

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

#### **N. 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.

We Cover biomarker precision medical testing, including both single-analyte tests and multiplex panel tests, performed at a participating laboratory that is either CLIA certified or CLIA waived by the FDA, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring to guide treatment decisions for Your disease or condition when one or more of the following recognizes the efficacy and appropriateness of such testing:

- Labeled indications for a test approved or cleared by the FDA or indicated tests for an FDA approved Prescription Drug;
  - Centers for Medicare and Medicaid Services ("CMS") national coverage determinations or Medicare administrative contractor local coverage determinations;
  - Nationally recognized clinical practice guidelines; or
- Peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

#### **O. Maternity and Newborn Care.**

1. 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]].

~~We also Cover the outpatient use of pasteurized donor human milk, which may include fortifiers, 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.~~

2. We Cover services provided by a Doula when recommended by Your Physician or midwife, [physician assistant] or nurse practitioner or as otherwise provided for under state law. For services of a Doula to be Covered, the Doula must be registered in the New York State Community Doula directory in accordance with Title VI-a of Article 25 of the New York Public Health Law.

We Cover eight (8) prenatal or postpartum visits per pregnancy. We Cover one (1) in-person Doula support visit during labor and birth per pregnancy.

#### **P. 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.}*

#### **Q. 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.}*

#### **R. Preadmission Testing.**

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



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

#### **S. 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 benefit applies when Your Provider orders the Prescription Drug and administers it to You.

When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this [Contract; Policy].

#### **T. Rehabilitation Services.**

*{Drafting Note: use the paragraphs below for Essential Plans 1, 2, and 200-250}*

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.}*

**[[U.] 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 [V]. Second Opinions.**

- 1. Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis [when Your attending Physician provides a written Referral to a non-participating Specialist].  
*{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 [W]. Surgical Services.**

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

*{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 [X]. Oral Surgery.**

We Cover the following limited dental and oral surgical procedures:

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

#### **X [Y]. . Reconstructive Breast Surgery.**

We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. Breast or chest wall reconstruction surgery includes the tattooing of the nipple-areolar complex if such tattooing is performed by a Health Care Professional. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

#### **Y [Z]. Other Reconstructive and Corrective Surgery.**

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

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

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

#### **[Z.][aa.] [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.}*

**[aa.][bb.] 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. If services must be performed at the Centers of Excellence -or otherwise designated Hospitals, insert the corresponding provision in the Inpatient Services section designation is included, insert the Centers of Excellence provision in the Inpatient Services section. If transplants must be performed at Centers of Excellence or otherwise designated Hospitals, include the reference to appeal rights.}*

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

**[See the Utilization Review and External Appeal sections of this [Certificate; Contract; Policy] for Your right to an internal Appeal and external appeal of Our determination that a transplant must be performed at a Center of Excellence; designated Hospital.]**

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 medical expenses 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 donor or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.