This is Your

EXCLUSIVE PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE

Administered by

CareConnect Administrative Services, Inc.
2200 Northern Boulevard, Suite 104, East Hills, New York 11548

This Certificate of Coverage ("Certificate") explains the benefits available to You under the CareConnect Northwell Health Employee Plan administered by CareConnect Administrative Services, Inc. (hereinafter referred to as "We", "Us" or "Our"). This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

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

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE SUMMARY PLAN DESCRIPTION. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

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

Alan Murray, President & CEO

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

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

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

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

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

Certificate: This Certificate administered by CareConnect Administrative Services, Inc., including the Schedule of Benefits and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

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

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

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

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

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied.

Dependents: The Subscriber's Spouse and Children.

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

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

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

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

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

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

Exclusions: Health care services that We do not pay for or which are not Covered Services.

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

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

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

Group: The employer or party that has entered into an agreement with Us to administer this Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

section of this Certificate.

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

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

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

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

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

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

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

Service Area: The geographical area in which Coverage is provided. Our Service Area consists of: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester counties in the State of New York.

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

Specialist: A Physician who focuses on a specific area of medicine or a group of

patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

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

Subscriber: The person to whom this Certificate is issued.

Summary Plan Description: The 2016 North Shore-LIJ Health System plan document which describes the health benefits available to You and Your Dependents under the North Shore-LIJ Health System Health & Welfare Flex Benefit Program.

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

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility that provides Urgent Care.

Us, We, Our: CareConnect Administrative Services, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

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

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the "Group") has engaged Us to administer the CareConnect Northwell Health Employee Plan. We will administer the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Your Provider directory, available at Your request;
- Call (855) 706-7545; or
- Visit Our website at CareConnect.com.

D. The Role of Primary Care Physicians.

This Certificate does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). Although you are encouraged to receive care from Your PCP, You do not need a Referral from a PCP before receiving Specialist care from a Participating Provider.

Access to Providers and Changing Providers. Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is accepting new patients.

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

E. Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible for requesting Preauthorization for the in-network

services.

F. Preauthorization/Notification Procedure.
If You seek coverage for services that require Preauthorization, Your Provider must call Us at (855) 706-7545 or Our vendor at the number on your ID card.

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.

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.

G. Medical Management.
The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered. 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.

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

We may base Our decision on a review of:

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

contrary opinions.

Services will be deemed Medically Necessary only if:

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

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

I. Protection from Surprise Bills.

1. A surprise bill is a bill You receive for Covered Services in the following circumstances:
    - For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
        - A participating Physician is unavailable at the time the health care services are performed;
        - A non-participating Physician performs services without Your knowledge; or
        - Unforeseen medical issues or services arise at the time the health care services are performed.

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

    - You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs that are not Covered. For a surprise bill, a referral to a Non-Participating Provider means:

        - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
        - The participating Physician sends a specimen taken from You in

the participating Physician's office to a non-participating laboratory or pathologist; or

- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

2. **Independent Dispute Resolution Process.** You may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Your payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

J. Delivery of Covered Services Using Telehealth.
If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

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

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

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

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us

to administer the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop administering extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

L. Important Telephone Numbers and Addresses.

- CLAIMS

CareConnect Administrative Services, Inc.
Attn: Claims
P.O. Box 830259
Birmingham, AL 35283-0209
(Submit claim forms to this address.)

questions@nslijcc.com
(Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS

CareConnect Administrative Services, Inc.
Attn: Grievance & Appeals Unit
2200 Northern Blvd., Suite 104
East Hills, NY 11548

- MEDICAL EMERGENCIES AND URGENT CARE

North Shore-LIJ Center for Emergency Services at (516) 719-5000/ (631) 719-5000
Or 911

- MEMBER SERVICES

(855) 706-7545
(Member Services Representatives are available Monday - Friday, 8:00 a.m. – 11:00 p.m. and Saturday and Sunday from 9 a.m. to 5 p.m.)

- PREAUTHORIZATION

(855) 706-7545

- OUR WEBSITE

CareConnect.com

SECTION III

Access to Care and Transitional Care

A. 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 an authorization to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of 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 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 paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When Your Provider Leaves the Network.

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

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

C. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course

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

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

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
There is no Deductible for Covered Services under this Certificate during each Plan Year.

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

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

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

Cost-Sharing for out-of-network services, except for Emergency Services and out of network dialysis, does not apply toward Your Out-of-Pocket Limit.

The Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Allowed Amount.
“Allowed Amount” means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider’s charge, if less.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.
You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. You must live, work, or reside in Our Service Area to be covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

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

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

Please see the Summary Plan Description for additional information regarding who is covered.

C. Children Covered Under this Certificate.
If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are Covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child

remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

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

SECTION VI

Preventive Care

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

Preventive Care.
The following services are Covered for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at (855) 706-7545 or visit Our website at CareConnect.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care. Well-baby and well-child care are Covered which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. 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 are also Covered. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance .

B. Adult Annual Physical Examinations. 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 are Covered.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the

Covered preventive Services is available on Our website at CareConnect.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

C. Adult Immunizations. Adult immunizations as recommended by ACIP are Covered. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP.

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

E. Mammograms. Mammograms for the screening of breast cancer are Covered as follows:

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

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

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

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

may be subject to Copayments or Coinsurance.

F. Family Planning and Reproductive Health Services. 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 Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women are Covered. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Vasectomies are Covered and are subject to Copayments or Coinsurance.

Services related to the reversal of elective sterilizations are not Covered.

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

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

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

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

H. Screening for Prostate Cancer. An annual standard diagnostic examination is Covered 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. 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 are also Covered.

This benefit is not subject to Copayments, Deductibles or Coinsurance.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition are Covered 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. However, transportation to a Hospital is Covered only when provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

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

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

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

Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide are Covered.

B. Non-Emergency Ambulance Transportation.

Non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities is Covered 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.

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

SECTION VIII

Emergency Services and Urgent Care

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

A. Emergency Services.

Emergency Services for the treatment of an Emergency Condition in a Hospital are Covered.

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. Emergency Services to treat Your Emergency Condition will also be Covered worldwide. However, only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital will be Covered.

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**.

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

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

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

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be the 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. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare.

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

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

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a

reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evening and weekends. **Urgent Care is Covered in or out of Our Service Area**.

1. **In-Network.** Urgent Care from a participating Physician or a participating Urgent Care Center is Covered.
2. **Out-of-Network**. Urgent Care from non-participating Urgent Care Centers is not Covered.

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

SECTION IX

Outpatient and Professional Services
(for other than Mental Health and Substance Use)

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

A. Acupuncture.
Acupuncture services rendered by a Health Care Professional licensed to provide such services are Covered.

B. Advanced Imaging Services.
PET scans, MRI, nuclear medicine, and CAT scans are Covered.

C. Allergy Testing and Treatment.
Testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy are Covered. Allergy treatment, including desensitization treatments, routine allergy injections and serums, is also Covered.

D. Ambulatory Surgical Center Services.
Surgical procedures performed at Ambulatory Surgical Centers are Covered, including services and supplies provided by the center the day the surgery is performed.

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

F. Chiropractic Services.
Chiropractic care is Covered 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 Certificate.

G. Clinical Trials.
Routine patient costs for Your participation in an approved clinical trial are Covered 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 section of this Certificate.

The following are not Covered: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

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

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

H. Dialysis.

Dialysis treatments of an Acute or chronic kidney ailment are Covered.
Dialysis treatments provided by a Non-Participating Provider are also Covered subject to all the following conditions:

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

I. Habilitation Services.

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 lifetime are Covered. 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.

J. Home Health Care.
Care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency is Covered. 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 200 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 or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

K. Infertility Treatment.
Services for the diagnosis and treatment (surgical and medical) of infertility are Covered when such infertility is the result of malformation, disease or dysfunction. Such Coverage is available as follows:

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

   Basic infertility services include:
   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultra sound;
   - Hysterosalpingogram;

- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

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

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

   Comprehensive infertility services include:
   - Ovulation induction and controlled ovarian stimulation;
   - Pelvic ultra sound;
   - Artificial insemination and intrauterine insemination;
   - Hysteroscopy;
   - Laparoscopy;
   - Assisted Reproductive Technologies (ART), including but not limited to, In vitro fertilization (IVF), gamete intrafallopian tube transfers (GIFT), zygote intrafallopian tube transfers (ZIFT) and Intra Cytoplasmic Sperm Injection;
   - Embryo transportation related network disruption;
   - Pre-implantation Genetic Diagnosis for diagnosis of genetic disorders only;
   - Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA)-male factor associated surgical procedures for retrieval of sperm;
   - Fertility preservation for cancer patients;
   - Testing for determination of genetic conditions;
   - Cryopreservation-embryo's;
   - Laparotomy; and
   - Prescription Drugs for the treatment of infertility that are included on Our Formulary. Certain Prescription Drugs that are not on Our Formulary and are used for ART for the treatment of infertility are Covered up to a $15,000 lifetime maximum for the cost of such Prescription Drugs (this lifetime limit does not include costs incurred under the Northwell Health Employee Plan when administered by other plan administrators). Call Us at (855)-706-7545 to determine which non-formulary Prescription Drugs will be covered for ART treatment.

3. **Exclusions and Limitations.** The following are not Covered:
   - See bullet above for limits related to coverage of non-formulary Prescription Drugs for the treatment of infertility through ART;
   - ART, including but not limited to, IVF, GIFT, or ZIFT are limited up to three (3) cycles per Member during the entire period you are Covered under the CareConnect Northwell Health Employee Plan (*i.e.,* ART cycles used by

the Member under the Northwell Health Employee Plan administered by other plan administrators count toward this lifetime limit);
- Costs for an ovum donor or donor sperm;
- Sperm storage costs;
- Storage of embryos;
- Long-term storage of other reproductive materials;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Selective breeding;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning;
- Cryopreservation and other forms of preservation of reproductive materials; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an external review.

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.

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

M. Interruption of Pregnancy.
Therapeutic abortions are Covered. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also Covered. Elective abortions for one (1) procedure per Member, per Plan Year are Covered.

N. Laboratory Procedures, Diagnostic Testing and Radiology Services.
X-ray, laboratory procedures and diagnostic testing, services and materials are Covered, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

O. Maternity and Newborn Care.
Services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center are Covered. Prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy are Covered. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to

Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

The cost of renting one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor is Covered.

P. Medications for Use in the Office.
Medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes are Covered. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

Q. Office Visits.
Office visits for the diagnosis and treatment of injury, disease and medical conditions are Covered. Office visits may include house calls.

R. Outpatient Hospital Services.
Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility are Covered. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Pulmonary and cardiac rehabilitation in a Specialist's office are also Covered.

S. Preadmission Testing.
Preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital is Covered 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.

T. Rehabilitation Services.
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 lifetime are Covered. 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.
Speech and physical therapy is Covered only when:

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

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

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

U. Second Opinions.

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

2. **Second Surgical Opinion.** A second surgical opinion by a qualified Physician on the need for surgery is Covered.

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.

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

V. Surgical Services.

Physicians' services for surgical procedures are Covered, 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.

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.

The following limited dental and oral surgical procedures are Covered:

- 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. Reconstructive Breast Surgery.

Breast reconstruction surgery after a mastectomy or partial mastectomy is Covered. 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. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

Y. Other Reconstructive and Corrective Surgery.

Reconstructive and corrective surgery other than reconstructive breast surgery is Covered only when it is:

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

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

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

Hospital and medical expenses, including donor search fees, of the Member-recipient are Covered. Transplant services required by You when You serve as an organ donor are Covered only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

The following are not Covered: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X

Additional Benefits, Equipment and Devices

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

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

1. **Screening and Diagnosis.** Assessments, evaluations, and tests to determine whether someone has autism spectrum disorder are Covered.

2. **Assistive Communication Devices.** A formal evaluation by a speech-language pathologist is Covered to determine the need for an assistive communication device. Based on the formal evaluation, the rental or purchase of assistive communication devices is Covered 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. Only devices that generally are not useful to a person in the absence of a communication impairment will be Covered. Items, such as, but not limited to, laptops, desktop, or tablet computers are not Covered. Software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device are Covered. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   Repair, replacement fitting and adjustments of such devices is Covered when made necessary by normal wear and tear or significant change in Your physical condition. The cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft is not Covered; Coverage will be provided for the device most appropriate to Your current functional level. Delivery or service charges or routine maintenance is not Covered.

3. **Behavioral Health Treatment.** Counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable,

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

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

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

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

   You are responsible for any applicable Copayment, Deductible or Coinsurance

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

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

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

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

2. Self-Management Education.

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Education on self-management and nutrition is Covered 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. Only basic models of blood glucose monitors are Covered unless You have special needs relating to poor vision or blindness.

C. Durable Medical Equipment and Braces.

The rental or purchase of durable medical equipment and braces is Covered.

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. The cost of repair or replacement is

Covered when made necessary by normal wear and tear. The cost of repair or replacement that is the result of misuse or abuse by You is not Covered. We will determine whether to rent or purchase such equipment. Over-the-counter durable medical equipment is not Covered.

Equipment designed for Your comfort or convenience is not Covered (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.**
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 are Covered. Coverage is for standard equipment only. Replacements when growth or a change in Your medical condition make replacement necessary are Covered. The cost of repair or replacement that is the result of misuse or abuse by You is not Covered.

D. Hearing Aids.
External 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) are Covered for Dependents under the age of 26 who are covered under this Certificate. External hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. An external hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for an external hearing aid that is purchased as a result of a written recommendation by a Participating Provider who is a Physician and include the external hearing aid and the charges for associated fitting and testing. Up to one pair of external hearing aids (including repair and/or replacement) is Covered every Plan Year. External hearing aids and hearing aid accessories are Covered up to a $15,000 annual maximum for the cost of such external hearing aids and hearing aid accessories. You will be reimbursed directly through Us for the costs of external hearing aids and hearing aid accessories covered under this Certificate. For further information, please call Us at (855) 706-7545.

Bone anchored hearing aids are Covered only if You have either of the following:
- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. Repair and/or replacement of a bone anchored hearing aid is Covered only for malfunctions.

E. Hospice.
Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. Inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies are Covered. Coverage is provided for 210 days of Hospice Care per Plan Year. Five (5) visits for supportive care and guidance are Covered 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.

Hospice Care is Covered 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. The following are not Covered: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

F. Medical Supplies.
Medical supplies are Covered when they are required for the treatment of a disease or injury which is Covered under this Certificate. Maintenance supplies (e.g., ostomy supplies) are also Covered when they are for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. Over-the-counter medical supplies are not Covered. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. External Prosthetic Devices.
Prosthetic devices (including wigs) are Covered when they are worn externally and temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Wigs are Covered 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). Wigs are not Covered when they are made from human hair unless You are allergic to all synthetic wig materials.

Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Certificate.

Shoe inserts are not Covered.

External breast prostheses following a mastectomy are Covered and are not subject to any lifetime limit.

Coverage is for standard equipment only.

The cost of one (1) prosthetic device, per limb, per lifetime is Covered. The cost of repair and replacement of the prosthetic device and its parts are also Covered. The cost of repair or replacement is not Covered when it is covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

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

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

Coverage is for standard equipment only.

SECTION XI

Inpatient Services
(for other than Mental Health and Substance Use)

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

A. Hospital Services.
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 are Covered including:

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

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

B. Observation Services.
Observation services in a Hospital are Covered. 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.
Medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate are Covered.

D. Inpatient Stay for Maternity Care.
Inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, are Covered 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. Any additional days of such care that We determine are Medically Necessary will also be Covered. 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, a home care visit will be Covered. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

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

F. Autologous Blood Banking Services.
Autologous blood banking services are Covered 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, storage fees are Covered for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Rehabilitation Services.
Inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy are Covered for up to one (1) consecutive 60 day period per condition per lifetime. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

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

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

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

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

I. End of Life Care.
If You are diagnosed with advanced cancer and You have fewer than 60 days to live, Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients will be Covered. 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 review. The Facility will be reimbursed for Your care and Your care will be Covered, subject to any applicable limitations in this Certificate until the external review agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. Limitations/Terms of Coverage.
1. When You are receiving inpatient care in a Facility, 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 will not be Covered. 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. Radio, telephone or television expenses, or beauty or barber services are not Covered.
3. Any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, are not Covered unless Our denial is overturned by an external review agent.

SECTION XII

Mental Health Care and Substance Use Services

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

A. Mental Health Care Services.

1. **Inpatient Services.** Inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate are Covered. 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.

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

2. **Outpatient Services.** Outpatient mental health care services are Covered, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of

additional experience in psychotherapy or a professional corporation or a university faculty practice corporation thereof.

3. Limitations/Terms of Coverage. The following are not Covered:

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

B. Substance Use Services.

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

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

2. Outpatient Services. Outpatient substance use services relating to the diagnosis and treatment of substance use disorder , including methadone treatment are Covered. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic

medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

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

SECTION XIII

Prescription Drug Coverage

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

A. Covered Prescription Drugs.

Medically Necessary Prescription Drugs are Covered when, except as specifically provided otherwise, they can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.

- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (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.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at CareConnect.com. You may inquire if a specific drug is Covered under this Certificate by contacting Us at (855) 706-7545.

B. Refills.

Refills of Prescription Drugs are Covered only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after 82% 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 Certificate.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order or Designated Pharmacy.

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

   An additional charge may apply when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request, when a chemically equivalent

Prescription Drug is available on a lower tier unless We approve coverage at the higher tier. You will have to pay the difference between the cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference must be paid in addition to the lower tier Copayment or Coinsurance. The cost difference does not apply toward Your Out-of-Pocket Limit.

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

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order or Designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.

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

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at (855) 706-7545 or visit Our website at CareConnect.com to request approval.

3. **Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

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

   Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

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

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

- Acromegaly
- Alpha1-antitrypsin (AAT) deficiency
- Anemia
- Cardiac disorders
- Central precocious puberty (CPP)
- Cystic fibrosis
- Electrolyte disorders
- Growth hormone (GH) and related disorders
- Hematopoietics
- Hepatitis
- Hormonal therapies
- HIV
- Immune therapies
- Immune (idiopathic) thrombocytopenia (ITP)
- Infectious disease
- Infertility
- Inflammatory bowel disease (IBD)
- Iron overload
- Lysosomal storage disorders (LSD) and related disorders
- Movement disorders
- Multiple sclerosis (MS)
- Neutropenia
- Oncology
- Osteoporosis
- Psoriasis
- Pulmonary arterial hypertension (PAH)
- Renal disorders
- Rheumatoid arthritis (RA)
- Seizure disorders

To obtain a list of specialty Prescription Drugs included in this program, as updated from time to time, please call (855) 706-7545.

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

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

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

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

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

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 or Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

6. **Tier Status.** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six (6) times per Plan Year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at CareConnect.com or by calling (855) 706-7545.

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

8. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external review as outlined in the Summary Plan Description. Call (855) 706-7545 to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no

later than 72 hours after Our receipt of Your request. If We approve the request, the Prescription Drug will be Covered while You are taking the Prescription Drug, including any refills.

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

9. **Supply Limits.** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. 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 up to three (3) Cost-Sharing amounts for a 90-day supply at a retail 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 and a half (2.5) Cost-Sharing amounts for a 90-day supply.

   Specialty Prescription Drugs are limited to a 30-day supply. Call (855) 706-7545 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 CareConnect.com or by calling (855) 706-7545. 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 section of this Certificate.

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

section of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Certificate.

11. **Half Tablet Program.** Certain Prescription Drugs may be designated as eligible for Our voluntary half tablet program. This program provides the opportunity to reduce Your Prescription Drug out-of-pocket expenses by up to 50% by using higher strength tablets and splitting them in half. If You are taking an eligible Prescription Drug, and You would like to participate in this program, please call Your Physician to see if the half tablet program is appropriate for Your condition. If Your Physician agrees, he or she must write a new prescription for Your medication to enable Your participation.

You can determine whether a Prescription Drug is eligible for the voluntary half tablet program by calling (855) 706-7545.

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

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

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at CareConnect.com or call (855) 706-7545. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Certificate. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one or more types of Prescription Drug before another will be Covered as Medically Necessary. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list.

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. For questions or issues about therapeutic drug substitutes, call (855) 706-7545.

E. Limitations/Terms of Coverage.

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

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

3. Compounded Prescription Drugs will be Covered only when 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 3.

4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. Charges for the administration or injection of any Prescription Drug are not Covered. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Certificate.

7. Drugs that do not by law require a prescription are not Covered, except for smoking cessation drugs or as otherwise provided in this Certificate. Prescription

Drugs that have over-the-counter non-prescription equivalents are not Covered, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

8. Prescription Drugs to replace those that may have been lost or stolen are not Covered.

9. Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient are not Covered, 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 section of this Certificate.

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

F. General Conditions.

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

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

amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

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

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

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

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at CareConnect.com or by calling (855) 706-7545.

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

5. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

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

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

7. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to

a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

8. **Prescription Drug Cost:** The rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

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

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

SECTION XIV

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.
Services arising out of aviation are not Covered, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

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

C. Cosmetic Services.
Cosmetic services, Prescription Drugs, or surgery are not Covered, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review section of this Certificate unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico.
Care or treatment provided outside of the United States, its possessions, Canada or Mexico is not Covered except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

E. Dental Services.
Dental services are not Covered except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services sections of this Certificate.

F. Experimental or Investigational Treatment.
Any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational is not Covered. However, experimental or investigational treatments will be Covered, including treatment for Your rare disease or

patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an external review agent. However, for clinical trials, the following will not be Covered: costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review section of this Certificate for a further explanation of Your Appeal rights.

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

H. Foot Care.
Routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet is not Covered. However, 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 will be Covered.

I. Government Facility.
Care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity is not Covered, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

J. Medically Necessary.
In general, any health care service, procedure, treatment, test, device or Prescription Drug is not Covered when We determine that it is not Medically Necessary. If an external review agent overturns Our denial, however, the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied will be Covered, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.
Services are not Covered if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.
An illness, treatment or medical condition due to service in the Armed Forces or auxiliary units is not Covered.

M. No-Fault Automobile Insurance.
Benefits are not Covered to the extent provided for any loss or portion thereof for which

mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Services Not Listed.
Services that are not listed in this Certificate as being Covered are not Covered.

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

P. Services Separately Billed by Hospital Employees.
Services rendered and separately billed by employees of Hospitals, laboratories or other institutions are not Covered.

Q. Services with No Charge.
Services for which no charge is normally made are not Covered.

R. Vision Services.
The examination or fitting of eyeglasses or contact lenses is not Covered.

S. War.
An illness, treatment or medical condition due to war, declared or undeclared, is not Covered.

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

SECTION XV

Claim Determinations

A. Claims.

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

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling (855) 706-7545 or visiting Our website at CareConnect.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card., You may also submit a claim to Us electronically by visiting Our website at CareConnect.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180 days, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

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

E. Claim Determinations.

The claim determination procedure described in this section 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. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

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

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 calendar days from receipt of the claim.

   If We need additional information, We will request it within 15 calendar days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 calendar days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 calendar days of Our receipt of the information. If all necessary information is not received within 45 calendar days, We will make a determination within 15 calendar days of the end of the 45 calendar 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. An “urgent” pre-service request is a request for medical care or treatment for which the application of the time periods for making non-urgent determinations could seriously jeopardize Your life or health or Your ability to regain maximum function, or, in the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

G. Post-Service Claim Determinations.

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

SECTION XVI

Grievance Procedures

A. Grievances.
Our Grievance procedure applies to any issue or adverse benefit determination not relating to a Medical Necessity (including whether a service or treatment is 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. An "adverse benefit determination" is a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply, or benefit.

B. Filing a Grievance.
You can contact Us by phone at (855) 706-7545, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision to file the Grievance. The Grievance constitutes a first level mandatory internal Appeal of the claims decision.

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.

You may submit written comments, documents, records, and other information relating to Your claim, whether or not they were submitted in connection with Your initial claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by You or Your authorized representative. You may also request that We provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

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

C. Grievance Determination.
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. The personnel reviewing the Grievance will not give deference to the initial adverse benefit determination, and the Grievance will be reviewed by personnel who are neither the individual who made the adverse benefit determination being appealed nor the subordinate of such individual. 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 a treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.
If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at (855) 706-7545, in person, or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal. The Appeal constitutes a second level mandatory internal Appeal.

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

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. The personnel reviewing the Grievance will not give deference to the initial adverse benefit determination or the Grievance determination being appealed.

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Us (or at Our direction), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is provided, to give you a reasonable opportunity to respond prior to that date.

We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or a treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance.
For questions about Your rights or for assistance, You may contact the Employee Benefit Security Administration at 1-866-444-EBSA (3272) or 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

F. Exhaustion of Grievance Process.
Generally, you are required to complete all Appeal processes before being able to bring an action in litigation. However, if We do not strictly adhere to all claim determination and Appeal requirements under applicable federal law, You are considered to have exhausted the plan's Appeal requirements ("Deemed Exhaustion") and may pursue any available remedies under Section 502 of ERISA or under state law, as applicable. There is an exception to the Deemed Exhaustion rule if a rule violation was minor and is not likely to influence a decision or harm you, was for a good cause or beyond Our control, and was part of an ongoing good faith exchange between You and Us.

SECTION XVII

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary (including whether a service or treatment is experimental or investigational). 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 (855) 706-7545. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call (855) 706-7545.

B. Preauthorization Reviews.

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

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

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

Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. An "urgent" Preauthorization request is a request for medical care or treatment for which the application of the time periods for making non-urgent determinations could seriously jeopardize Your life or health or Your ability to regain maximum function, or, in the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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 15 calendar days of the end of the 45-day period.

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

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) 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 time period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours

prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

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

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

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

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

G. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an

internal Appeal of an adverse benefit determination, either by phone, in person, or in writing. An "adverse benefit determination" is a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply, or benefit.

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, if necessary, inform You of any additional information needed before a decision can be made.

You may submit written comments, documents, records, and other information relating to Your claim, whether or not they were submitted in connection with Your initial claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by You or Your authorized representative. You may also request that We provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Us (or at Our direction), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is provided, to give you a reasonable opportunity to respond prior to that date.

A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination (or the first level Appeal in the case of a second level Appeal) will perform the Appeal. The person reviewing the Appeal will not give deference to the initial adverse benefit determination (or to the first level Appeal decision in the case of a second level Appeal).

H. First Level

The first level Appeal constitutes a first level mandatory internal Appeal of the claims decision.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

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

Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a second internal Appeal and/or an appeal for an external review.

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 appeal for external review within 24 hours of receipt of Our adverse determination, coverage for the inpatient substance use disorder treatment will be provided while a determination on the internal Appeal and external review is pending.

I. Second Level Appeal.

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. The second level Appeal constitutes a second level mandatory internal Appeal of the claims decision.

You or Your designee can also initiate an external review by an independent review organization. An external review is available with respect to final adverse determinations (generally after the second level of Our internal Appeal process). Your claim is not eligible for external review if it involves a denial, reduction, termination or failure to meet the requirements for eligibility under the terms of the CareConnect Northwell Health Employee Plan, or a legal or contractual interpretation of its terms. **Please see the Summary Plan Description for additional information regarding external reviews.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal**. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

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

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

J. Appeal Assistance.
For questions about Your rights or for assistance, You may contact the Employee Benefit Security Administration at 1-866-444-EBSA (3272) or 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

K. Exhaustion of Internal Appeals Process.
Generally, you are required to complete all Appeal processes before being able to obtain an External Review or bring an action in litigation. However, if We do not strictly adhere to all claim determination and Appeal requirements under applicable federal law, You are considered to have exhausted the plan's Appeal requirements ("Deemed Exhaustion") and may proceed with External Review or pursue any available remedies under Section 502 of ERISA or under state law, as applicable. There is an exception to the Deemed Exhaustion rule if a rule violation was minor and is not likely to influence a decision or harm you, was for a good cause or beyond Our control, and was part of an ongoing good faith exchange between You and Us.

SECTION XVIII

Termination of Coverage

Please see the Summary Plan Description for information regarding when Your Coverage ends. Please see the Continuation of Coverage section of this Certificate for Your right to continuation of this Coverage.

SECTION XIX

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

A. Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or

2. The date You are sent notice by first class mail of the right of continuation by the Group.

Continued coverage under this section will terminate at the earliest of the following (among other circumstances):

1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare under certain circumstances, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage; or
4. The date You become entitled to Medicare.

.Please see the Summary Plan Description for additional information.

B. Supplementary Continuation Rights During Active Duty.

.Please see the Summary Plan Description for additional information regarding Your rights to continued Coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

SECTION XX

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Certificate to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. Changes in this Certificate.
We may unilaterally change this Certificate upon renewal, if We give the Group 45 days' prior written notice.

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

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

6. Continuation of Benefit Limitations.
Some of the benefits in this Certificate 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, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

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

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

The Group will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Group's Contract; Policy with Us. If the Group fails to so advise Us, the Group will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

8. Entire Agreement.
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

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.
The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

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 Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

12. Incontestability.

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

13. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. Material Accessibility.
We will give the Group, and the Group will give You ID cards, Certificates, riders, and other necessary materials.

15. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

16. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: CareConnect Administrative Services, Inc., 2200 Northern Boulevard, Suite 104, East Hills, NY 11548.

17. Premium Refund.
We will give any refund of Premiums, if due, to the Group.

18. Recovery of Overpayments.
On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate

overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

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

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

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

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

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

23. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating

Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

24. Subrogation and Reimbursement.

The right to subrogation means that the CareConnect Northwell Health Employee Plan is substituted to and shall succeed to any and all legal claims that You may be entitled to pursue against any third party for Covered Services that We have paid for which a third party is considered responsible. Subrogation applies when the Covered Services have been paid on Your behalf for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The CareConnect Northwell Health Employee Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any Covered Services We have paid on Your behalf for which a third party is considered responsible.

The right to reimbursement means that if a third party is responsible for the receipt of Covered Services under this Certificate for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to CareConnect Northwell Health Employee Plan 100% of any payment for such Covered Services.

25. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

26. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

27. Translation Services.

Translation services are available under this Certificate for non-English speaking Members. Please contact Us at (855) 706-7545 to access these services.

28. Venue for Legal Action.
If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

31. Who Receives Payment under this Certificate.
If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider, regardless of whether an assignment has been made.

32. Workers' Compensation Not Affected.
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Medical Records and Reports.
In order to administer Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to administer that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

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

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

34. Your Rights.

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

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

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

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