Empire BlueCross BlueShield

An Anthem Company

Essential Plan 4 Subscriber Contract

New York

1024983NYMENEBS 09/22

An Anthem Company

Essential Plan 4
Subscriber Contract
New York

1024983NYMMLEBS 09/22

This is your

ESSENTIAL PLAN
CONTRACT

Issued by

EMPIRE BLUECROSS BLUESHIELD HEALTHPLUS

This is your individual contract for the Essential Plan coverage issued by Empire BlueCross BlueShield HealthPlus. This contract, together with the attached Schedule of benefits, applications, and any amendment or rider amending the terms of this contract, constitute the entire agreement between you and us.

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

Renewability
The renewal date for this contract is 12 months from the effective date of coverage. This contract will automatically renew each year on the renewal date, unless otherwise terminated by us as permitted by this contract or by you upon 30 days' prior written notice to us.

In-network benefits.
This contract only covers in-network benefits. To receive in-network benefits, you must receive care exclusively from participating providers and participating pharmacies in our Empire network who are located within our service area. Care covered under this contract (including hospitalization) must be provided, arranged, or authorized in advance by your primary care provider (PCP) and, when required, approved by us. In order to receive the benefits under this contract, you must contact your PCP before you obtain the services, except for services to treat an emergency condition described in the **Emergency services and urgent care** section of this contract. Except for care for an emergency or urgent condition described in the **Emergency services and urgent care** section of this contract, you will be responsible for paying the cost of all care that is provided by nonparticipating providers.

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

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

Sincerely,

Jennifer Kuhn
President

Empire BlueCross BlueShield HealthPlus

empireblue.com/nyessentialplan

Services provided by HealthPlus HP, LLC, a licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

TABLE OF CONTENTS

SECTION I - DEFINITIONS

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

Allowed amount: The maximum amount on which our payment is based for covered services. See the **Cost-sharing expenses and allowed amount** section of this contract 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 nonparticipating provider bills you for the difference between the nonparticipating provider's charge and the allowed amount. A participating provider may not balance bill you for covered services.

Contract: This contract issued by Empire BlueCross BlueShield HealthPlus, including the Schedule of benefits and any attached riders.

Coinsurance: Your share of the costs of a covered service, calculated as a percent of the allowed amount for the service that you are required to pay to a provider. The amount can vary by the type of covered service.

Copay: 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 copays and/ or coinsurance.

Cover, coverage, or covered services: The medically necessary services paid for, arranged or authorized for you by us under the terms and conditions of this contract.

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.
- 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 body part of such person.
- Serious disfigurement of such person.

Emergency department care: Emergency services you receive 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: Healthcare services that we do not pay for or cover.

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

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

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

Grievance: A complaint that you communicate to us that does not involve a utilization review determination.

Habilitation services: Healthcare 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. We cover inpatient habilitation services consisting

of physical therapy, speech therapy, and occupational therapy.

Healthcare professional: An appropriately licensed, registered, or certified physician, dentist, optometrist, chiropractor, psychologist, social worker, podiatrist, physical therapist, occupational therapist, midwife, speech-language pathologist, audiologist, pharmacist, behavior analyst, nurse practitioner; or any other licensed, registered or certified healthcare 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 healthcare professional's services must be rendered within the lawful scope of practice for that type of provider in order to be covered under this contract.

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

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

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

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

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

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

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay.

Lawfully present immigrant: The term "lawfully present" includes immigrants who have:

- "Qualified non-citizen" immigration status without a waiting period.
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking).
- Valid non-immigration visas.

- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals). To see a full list of eligible immigration statuses, please visit the website at healthcare.gov/immigrants/immigration-status or call the NY State of Health at 855-355-5777.

Medically necessary: See the **How your coverage works** section of this contract for the definition.

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

Network: The providers we have contracted with to provide healthcare services to you.

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

Nonparticipating provider: A provider who doesn't have a contract with us to provide healthcare services to you. The services of nonparticipating providers are covered only for emergency services or urgent care or when authorized by us.

Out-of-pocket limit: The most you pay during a plan year in cost sharing before we begin to pay 100 percent of the allowed amount for covered services. This limit never includes your premium, balance billing charges, or the cost of healthcare services we do not cover.

Participating provider: A provider who has a contract with us to provide healthcare services to you. A list of participating providers and their locations is available on our website at empireblue.com/nyessentialplan or upon your request to us. The list will be revised from time to time by us.

Physician or physician services: Healthcare services a licensed medical physician (MD — Medical Doctor) or DO (Doctor of Osteopathic Medicine) provides or coordinates.

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

Preauthorization: A decision by us prior to your receipt of a covered service, procedure, treatment plan, device, or prescription drug that the covered service, procedure, treatment plan, device, or prescription drug is medically necessary. We indicate which covered services require preauthorization in the **Schedule of benefits** section of this contract.

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 nonskilled caregiver.

Primary care provider (PCP): A participating nurse practitioner or provider who typically is an internal medicine or family practice provider and who directly provides or coordinates a range of healthcare services for you.

Provider: A physician, healthcare professional, or facility licensed, registered, certified, or accredited as required by state law. A provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are covered under this contract that is licensed, registered, certified, or accredited as required by state law.

Referral: An authorization given to one participating provider from another participating provider (usually from a PCP to a participating specialist) in order to arrange for additional care for the subscriber. A preauthorization can be transmitted by your provider completing a paper preauthorization form. A preauthorization is not required but is needed in order for you to pay the lower cost sharing for certain services listed in the **Schedule of benefits** section of this contract.

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

Schedule of benefits: The section of this contract that describes the copays, coinsurance, out-of-pocket limits, preauthorization requirements, and other limits on covered services.

Service area: The geographical area designated by us and approved by the state of New York, in which we provide coverage. Our service area consists of: Bronx, Delaware, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester counties.

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 provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Subscriber: The person to whom this contract is issued. Whenever a subscriber is required to

provide a notice pursuant to a grievance or emergency department admission or visit, subscriber also means the subscriber's designee.

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

Urgent care: Medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent care may be rendered in a provider's office or urgent care center.

Urgent care center: A licensed facility other than a hospital that provides urgent care.

Us, We, Our: Empire BlueCross BlueShield HealthPlus and anyone to whom we legally delegate performance, on our behalf, under this contract.

Utilization review: The review to determine whether services are or were medically necessary or experimental or investigational (e.g., treatment for a rare disease or a clinical trial).

You, Your: The subscriber.

SECTION II - HOW YOUR COVERAGE WORKS

A. Your coverage under this contract
You have purchased or been enrolled in an Essential Plan. We will provide the benefits described in this contract to you. You should keep this contract with your other important papers so that it is available for your future reference.

B. Covered services
You will receive covered services under the terms and conditions of this contract only when the covered service is all of these:

- Medically necessary
- Provided by a participating provider
- Listed as a covered service
- Not in excess of any benefit limitations described in the **Schedule of benefits** section of this contract
- Received while your contract is in force

When you are outside our service area, coverage is limited to emergency services, pre-hospital emergency medical services, and ambulance services to treat your emergency condition.

C. Participating providers
To find out if a provider is a participating provider, you can do one of the following:

- Check our provider directory, available at your request.
- Call 800-300-8181 (TTY 711).
- Visit our website at empireblue.com/nyessentialplan.

The provider directory will give you the following information about our participating providers:

- Name, address, and telephone number
- Specialty
- Board certification (if applicable)
- Languages spoken
- Whether the participating provider is accepting new patients

You are only responsible for any cost-sharing that would apply to the covered services if you receive covered services from a provider who is not a participating provider in the following situations:

- The provider is listed as a participating provider in our online provider directory;
- Our paper provider directory listing the provider as a participating provider is incorrect as of the date of publication;
- We give you written notice that the provider is a participating provider in response to your telephone request for network status information about the provider; or
- We do not provide you with a written notice within one (1) business day of your telephone request for network status information. In these situations, if a provider bills you for more than your in-network cost-sharing and you pay the bill, you are entitled to a refund from the provider, plus interest.

D. The role of primary care providers
This contract has a gatekeeper, usually known as a primary care provider (PCP). Although you are encouraged to receive care from your PCP, you do not need a written referral from a PCP before receiving specialist care. You may select any participating PCP who is available from the list of PCPs in the Essential Plan. In certain circumstances, you may designate a specialist as your PCP. See the **Access to care and transitional care** section of this contract for more information about designating a specialist. To select a PCP, log in to your secure account at empireblue.com/nyessentialplan or call Member Services at 800-300-8181 (TTY 711). If you do not select a PCP, we will assign one to you.

For purposes of cost sharing, if you seek services from a PCP (or a provider covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, you must pay the specialty office visit cost sharing in the **Schedule of benefits** section of this contract when the services provided are related to specialty care.

E. Services not requiring a referral from your PCP
Your PCP is responsible for determining the most appropriate treatment for your healthcare needs. You do not need a referral from your PCP to a participating provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of acute gynecologic conditions or for any care related to a pregnancy from a qualified participating provider of such services
- Emergency services
- Pre-hospital emergency medical services and emergency ambulance transportation
- Urgent care
- Chiropractic services
- Outpatient mental healthcare
- Outpatient substance abuse services
- Outpatient habilitation services (physical therapy, occupational therapy, or speech therapy)
- Outpatient rehabilitation services (physical therapy, occupational therapy, or speech therapy)
- Outpatient mental healthcare
- Refractive eye exams from an optometrist
- Diabetic eye exams from an ophthalmologist
- Home healthcare
- Diagnostic radiology services
- Laboratory procedures

However, the participating provider must:

- Discuss the services and treatment plan with your PCP.
- Agree to follow our policies and procedures including any procedures regarding referrals or referral for services other than obstetric and gynecologic services rendered by such participating provider.
- Agree to provide services pursuant to a treatment plan (if any) approved by us.

See the **Schedule of benefits** section of this contract for the services that require a referral.

F. Access to providers and changing providers
Sometimes, providers in our provider directory are not available. Prior to notifying us of the PCP you selected, you should call the PCP to make sure he or she is accepting new patients.

To see a provider, call his or her office and tell the provider that you are an Empire BlueCross BlueShield HealthPlus member, and explain the reason for your visit. Have your ID card available. The provider's office may ask you for your member ID number. When you go to the provider's office, bring your ID card with you.

To contact your provider after normal business hours, call the provider's office. You will be directed to your provider, an answering machine with directions on how to obtain services, or another provider. If you have an emergency condition, seek immediate care at the nearest hospital emergency department or call 911.

You may change your PCP by calling Member Services at 800-300-8181 (TTY 711) in the first 30 days after your first appointment with your PCP. After that, you can change once every six months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.

If we do not have a participating provider for certain provider types in the county in which you live or in a bordering county that is within approved time and distance standards, we will approve a referral to a specific nonparticipating provider until you no longer need the care or we have a participating provider in our network that meets the time and distance standards and your care has been transitioned to that participating provider. Covered services rendered by the nonparticipating 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.

G. Out-of-network services
The services of nonparticipating providers are not covered except emergency services and pre-hospital emergency medical services and ambulance services to treat your emergency condition, or unless specifically covered in this contract.

H. Services subject to preauthorization
Our preauthorization is required before you receive certain covered services. Your PCP is responsible for requesting preauthorization for in-network services listed in the **Schedule of benefits** section of this contract.

I. Preauthorization procedure
If you seek coverage for services that require preauthorization, your provider must call us at 800-300-8181 (TTY 711).

Your provider must contact us to request preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when your provider recommends inpatient hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when your provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in an ambulatory surgical center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a nonemergency condition.

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

J. Medical management

The benefits available to you under this contract are subject to pre-service, concurrent, and retrospective reviews to determine when services should be covered by us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered services must be medically necessary for benefits to be provided.

K. Medical necessity

We cover benefits described in this contract as long as the healthcare service, procedure, treatment, test, device, prescription drug, or supply (collectively, "service") is medically necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it medically necessary or mean that we have to cover it.

We may base our decision on a review of the following:

- Your medical records
- Our medical policies and clinical guidelines
- Medical opinions of a professional society, peer review committee, or other groups of providers
- Reports in peer-reviewed medical literature
- Reports and guidelines published by nationally-recognized healthcare 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 healthcare professionals in the generally-recognized health specialty involved
- The opinion of the attending providers, which have credence, but do not overrule contrary opinions

Services will be deemed medically necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for your illness, injury, or disease.

- They are required for the direct care and treatment or management of that condition.
- Your condition would be adversely affected if the services were not provided.
- They are provided in accordance with generally accepted standards of medical practice.
- They are not primarily for the convenience of you, your family, or your provider.
- They are not more costly than an alternative service or sequence of services that is at least as likely to produce equivalent therapeutic or diagnostic results.
- When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a provider's office or the home setting.

See the **Utilization review** and **External appeal** sections of this contract for your right to an internal appeal and external appeal of our determination that a service is not medically necessary.

L. Protection from surprise bills

1. Surprise bills. A surprise bill is a bill you receive for covered services in the following circumstances:

- For services performed by a non-participating provider at a participating hospital or ambulatory surgical center, when:
  - A participating provider is unavailable at the time the healthcare services are performed.
  - A nonparticipating provider performs services without your knowledge.
  - Unforeseen medical issues or services arise at the time the healthcare services are performed.

  A surprise bill does not include a bill for healthcare services when a participating provider is available and you elected to receive services from a nonparticipating provider.
- You were referred by a participating physician to a nonparticipating provider without your explicit written consent acknowledging that the preauthorization is to a nonparticipating provider and it may result in costs not covered by us. For a surprise bill, a preauthorization to a nonparticipating provider means:
  - Covered services are performed by a nonparticipating provider in the participating provider'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 nonparticipating laboratory or pathologist.
  - For any other covered services performed by a nonparticipating provider at the participating physician's request, when preauthorizations are required under your contract.

You will be held harmless for any nonparticipating provider charges for the surprise bill that exceed your cost-sharing. The non-participating provider may only bill you for your cost-sharing. You can sign a form to notify us and the non-participating provider that you received a surprise bill. The Surprise Bill Certification Form is available at dfs.ny.gov or you can visit our website at empireblue.com/ny for a copy of the form. You need to mail a copy of the form to us at the address on our website, on your ID card, or the address for Surprise Bill Certification Form in the Important Telephone Numbers and Addresses paragraph below and to your provider.

2. Independent dispute resolution process
Either Empire or a provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. The IDRE will determine whether our payment or the provider's charge is reasonable within 30 days of receiving the dispute.

M. Delivery of covered services using telehealth
Telehealth means the use of electronic information and communication technologies by a provider to deliver covered services to you while your location is different than your provider's location. If your provider offers covered services using telehealth, we will not deny the covered services because they are delivered using telehealth. Covered services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the contract that are at least as favorable as those requirements for the same service when not delivered using telehealth.

N. Case management
Case management helps coordinate services for members with healthcare 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 healthcare needs. This is reached through contact and teamwork with you and/or your authorized representative, treating providers, and other providers. In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs, which may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care through our case management program that is not listed as a covered service. We may also extend covered services beyond the benefit maximums of this contract. We will make our decision on a case-by-case basis if we determine the alternate or extended benefit is in the best interest of you and us.

Nothing in this provision shall prevent you from appealing our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your representative in writing.

O. Important telephone numbers and addresses
Member Services: 800-300-8181 (TTY 711)
Member Services representatives are available Monday through Friday, 8 a.m. to 8 p.m., and Saturday 9 a.m. to 5 p.m. Eastern time.

Claims

Submit claim forms to this address:
Claims
Empire BlueCross BlueShield HealthPlus
P.O. Box 61010
Virginia Beach, VA 23466-1010

Complaints, grievances, and utilization review appeals
Call 800-300-8181 (TTY 711) Monday through Friday. 8 a.m. to 8 p.m., and Saturday 9 a.m. to 5 p.m. or mail to this address:
Medical Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

Surprise Bill Certification Form
NYS Department of Financial Services
Consumer Assistance Unit/IDR Process
1 Commerce Plaza
Albany, NY 12257

Behavioral health services
800-300-8181 (TTY 711)

Our website: empireblue.com/nyessentialplan

SECTION III - ACCESS TO CARE AND TRANSITIONAL CARE

A. Referral to a nonparticipating provider
If we determine that we do not have a participating provider that has the appropriate training and experience to treat your condition, we will approve a preauthorization to an appropriate nonparticipating provider. Your participating provider must request prior approval of the preauthorization to a specific nonparticipating provider. Approvals of preauthorizations to nonparticipating providers will not be made for the convenience of you or another treating provider and may not necessarily be to the specific nonparticipating provider you requested. If we approve the preauthorization, all services performed by the nonparticipating provider are subject to a treatment plan approved by us in consultation with your PCP, the nonparticipating provider, and you. Covered services rendered by the nonparticipating provider will be paid as if they were provided by a participating provider. You will be responsible only for any applicable in-network cost sharing. In the event a preauthorization is not approved, any services rendered by a nonparticipating provider will not be covered.

B. When a specialist can be your primary care provider
If you have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, you may ask that a specialist who is a participating provider be your PCP. We will consult with the specialist and your PCP and decide whether the specialist should be your PCP. Any preauthorization will be pursuant to a treatment plan approved by us in consultation with your PCP, the specialist, and you. We will not approve a nonparticipating specialist unless we determine that we do not have an appropriate provider in our network. If we approve a nonparticipating specialist, covered services rendered by the nonparticipating specialist pursuant to the approved treatment plan will be paid as if they were provided by a participating provider. You will only be responsible for any applicable in-network cost sharing.

C. Standing preauthorization to a participating specialist
If you need ongoing specialty care, you may receive a “standing preauthorization” to a specialist who is a participating provider. This means that you will not need a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether you should have a standing preauthorization. Any preauthorization will be pursuant to a treatment plan approved by us in consultation with your PCP, the specialist, and you. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the specialist to provide your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing preauthorization to a nonparticipating specialist unless we determine that we do not have an appropriate provider in our network. If we approve a standing preauthorization to a nonparticipating specialist, covered services rendered by the nonparticipating specialist pursuant to the approved treatment plan will be paid as if they were provided by a participating provider. You will be responsible only for any applicable in-network cost sharing.

D. Specialty care center
If you have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, you may request a preauthorization to a specialty care center with expertise in treating your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government, or a national health organization as having special expertise to treat your disease or condition. We will consult with your PCP, your specialist, and the specialty care center to decide whether to approve such a preauthorization. Any preauthorization will be pursuant to a treatment plan developed by the specialty care center, and approved by us in consultation with your PCP or specialist and you. We will not approve a preauthorization to a nonparticipating specialty care center unless we determine that we do not have an appropriate specialty care center in our network. If we approve a preauthorization to a nonparticipating specialty care center, covered services rendered by the nonparticipating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network cost sharing.

E. When your provider leaves the network
If you are in an ongoing course of treatment when your provider leaves our network, then you may continue to receive covered services for the ongoing treatment from the former participating provider for up to 90 days from the date your provider's contractual obligation to provide services to you terminates. If you are pregnant, you may continue care with a former participating provider through delivery and any postpartum care directly related to the delivery.

The provider must accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the provider. The provider must also provide us necessary medical information related to your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining preauthorization, and a treatment plan approved by us. You will receive the covered services as if they were being provided by a participating provider. You will be responsible only for any applicable in-network cost sharing. Please note that if the provider was terminated by us due to fraud, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the provider's ability to practice continued treatment with that provider is not available.

F. New members in a course of treatment
If you are in an ongoing course of treatment with a nonparticipating provider when your coverage under this contract becomes effective, you may be able to receive covered services for the ongoing treatment from the nonparticipating provider for up to 60 days from the effective date of your coverage under this contract. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a nonparticipating provider if you are in the second or third trimester of a pregnancy when your coverage under this contract becomes effective. You may continue care through delivery and any postpartum services directly related to the delivery.

In order for you to continue to receive covered services for up to 60 days or through a pregnancy, the nonparticipating 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, 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. Copays
Except where stated otherwise, you must pay the copays, or fixed amounts, in the **Schedule of benefits** section of this contract for covered services. However, when the allowed amount for a service is less than the copay, you are responsible for the lesser amount.

B. Coinsurance
Except where stated otherwise, you must pay a percentage of the allowed amount for covered services. We will pay the remaining percentage of the allowed amount as shown in the **Schedule of benefits** section of this contract.

C. Out-of-pocket limit
When you have met your out-of-pocket limit in payment of cost-sharing for a plan year in the **Schedule of benefits** section of this contract, we will provide coverage for 100 percent of the allowed amount for covered services for the remainder of that plan year.

Cost-sharing for out-of-network services, except for emergency services and out-of-network services approved by us as an in-network exception and out-of-network dialysis does not apply toward your in-network out-of-pocket limit. The out-of-pocket limit runs on a plan year basis.

D. Allowed amount
"Allowed amount" means the maximum amount we will pay for the services or supplies covered under this contract, before any applicable copayment or coinsurance amounts are subtracted. We determine our allowed amount as follows:

The allowed amount will be the amount we have negotiated with the participating provider.

Our payments to participating providers may include financial incentives to help improve the quality of care and promote the delivery of covered services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific covered service provided to you. Your cost-sharing will not change based on any payments made to or received from participating providers as part of the financial incentive program.

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

See the **Emergency services and urgent care** section of this contract for the allowed amount for emergency services rendered by nonparticipating providers. See the **Ambulance and**

pre-hospital emergency medical services section of this contract for the allowed amount for pre-hospital emergency medical services rendered by nonparticipating providers.

SECTION V - WHO IS COVERED

A. Who is covered under this contract. You, the subscriber to whom this contract is issued, are covered under this contract. You must live or reside in our service area to be covered under this contract. You must have a household income of 138 percent or below and be a lawfully present immigrant who is not eligible for Medicaid. If you are enrolled in Medicare or Medicaid or affordable Employer Sponsored Health Insurance, are under 21 years old, greater than 64 years old, or you are pregnant, you are not eligible to purchase this contract.

You must report changes that could affect your eligibility throughout the year, including whether you become pregnant. If you become pregnant while enrolled in this product, you become eligible to obtain Medicaid. We strongly encourage pregnant women to enroll in Medicaid to ensure that newborns have continuous coverage from their birth, as newborns are not covered under the Essential Plan. If you transition to Medicaid, your newborn will automatically be enrolled in Medicaid from their birth without a gap in coverage.

B. Types of coverage
The only type of coverage offered under the Essential Plan is individual coverage, which means only you are covered. If additional members of your family are also covered under the Essential Plan, they will receive a separate contract and, if applicable, they will have a separate premium.

C. Enrollment
You can enroll under this contract during any time of the year. If you are a new applicant for coverage through the NYSOH, your coverage will begin on the first of the month that your plan selection is made. For example, if the NYSOH receives your Essential Plan selection on February 18, coverage under the plan will begin on February 1. Any services you received between February 1 and February 18 will be covered by us. If you had coverage through the NYSOH under a different program or plan and switch to an Essential Plan, your coverage will begin on the first of the month following your plan selection. For example, if you select an Essential Plan on February 19, your coverage would begin March 1.

SECTION VI - PREVENTIVE CARE

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization requirements that apply to these benefits.

Preventive care
We cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost sharing (copays, 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 800-300-8181 (TTY 711) or visit our website at empireblue.com/nyessentialplan for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Adult annual physical examinations
We cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the covered preventive services is available on our website at empireblue.com/nyessentialplan, or will be mailed to you upon request.

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

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

B. Adult immunizations
We cover adult immunizations as recommended by ACIP. This benefit is not subject to copays or coinsurance when provided in accordance with the recommendations of ACIP.

C. Well-woman examinations
We cover well-woman examinations, which consist of a routine gynecological examination, breast examination, and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating the cervical cancer screening tests. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the covered preventive services is available on our website at empireblue.com/nyessentialplan, or will be mailed to you upon request. This benefit is not subject to copays or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above.

D. Mammograms, screening, and diagnostic imaging for the detection of breast cancer
We cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms) for the screening of breast cancer as follows:

- One baseline screening mammogram for members age 35 through 39
- One screening mammogram annually for members age 40 and over

If a member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, we cover mammograms as recommended by the member's provider. However, in no event will more than one preventive screening per plan year be covered.

Mammograms for the screening of breast cancer are not subject to copays or coinsurance when provided by a participating provider.

We also cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds, and MRIs are not subject to copayments, deductibles, or coinsurance when provided by a participating provider and medically necessary.

E. Family planning and reproductive health services
We cover family planning services which consist of FDA-approved contraceptive methods prescribed by a provider, not otherwise covered under the **Prescription drug coverage** section of this contract, patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence and device insertion and removal; and sterilization procedures for women. Such services are not subject to copays or coinsurance when provided by a participating provider.

We also cover vasectomies subject to copays or coinsurance.

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

F. Bone mineral density measurements or testing
We cover bone mineral density measurements or tests, and prescription drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of prescription drugs is subject to the **Prescription drug coverage** section of this contract. Bone mineral density measurements or tests, drugs, or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for coverage if you meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if you meet any of the following:

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

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

This benefit is not subject to copays 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 and when provided by a participating provider.

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

This benefit is not subject to copayments, deductibles, or coinsurance when provided by a participating provider.

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

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

SECTION VII - AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization or preauthorization 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

1. Pre-hospital emergency medical services

We cover pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service.

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

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

An ambulance service must hold you harmless and may not charge or seek reimbursement from you for pre-hospital emergency medical services except for the collection of any applicable copayment, deductible, or coinsurance. In the absence of negotiated rates, we will pay a nonparticipating provider the usual and customary charge for pre-hospital emergency medical services, which shall not be excessive or unreasonable. The usual and customary charge for pre-hospital emergency medical services is the lesser of the FAIR Health rate at the 80th percentile or the provider's billed charges.

2. Emergency ambulance transportation

In addition to pre-hospital emergency services, we also cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water, or air ambulance) to the nearest hospital where emergency services can be performed. This coverage includes emergency ambulance transportation to a hospital when the originating facility does not have the ability to treat your emergency condition.

B. Nonemergency ambulance transportation

We cover nonemergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From a nonparticipating 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
- From an acute care facility to a sub-acute setting

C. Limitations/terms of coverage

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

SECTION VIII - EMERGENCY SERVICES AND URGENT CARE

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization or preauthorization requirements that apply to these benefits.

A. Emergency services
We cover emergency services for the treatment of an emergency condition in a hospital.

We define an **"emergency condition"** to mean: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

For example, an emergency condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention, such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of emergency services for treatment of your emergency condition will be provided regardless of whether the provider is a participating provider. We will also cover emergency services to treat your emergency condition worldwide. However, we will cover only those emergency services and supplies that are medically necessary and are performed to treat or stabilize your emergency condition in a hospital.

Please follow the instructions listed below regardless of whether or not you are in our service area at the time your emergency condition occurs:

1. Hospital emergency department visits
In the event that you require treatment for an emergency condition, seek immediate care at the nearest hospital emergency department, or call 911. Emergency department care does not require preauthorization. **However, only emergency services for the treatment of an emergency**

condition are covered in an emergency department. If you are uncertain whether a hospital emergency department is the most appropriate place to receive care, you can call us before you seek treatment. Our medical management coordinators are available 24 hours a day, seven days a week. Your coordinator will direct you to the emergency department of a hospital or other appropriate facility.

We do not cover follow-up care or routine care provided in a hospital emergency department. You should contact us to make sure you receive the appropriate follow-up care.

2. Emergency hospital admissions
In the event that you are admitted to the hospital, you or someone on your behalf must notify us at the number listed in this contract and on your ID card within 48 hours of your admission, or the next business day on a weekend, or as soon as is reasonably possible.

We cover inpatient hospital services following emergency department care at a nonparticipating hospital at the in-network cost sharing. If your medical condition permits your transfer to a participating hospital, we will notify you and work with you to arrange the transfer.

3. Payments relating to emergency services rendered
We will pay a participating provider the amount we have negotiated with the participating provider for the emergency services. The amount we pay a nonparticipating provider for emergency services will be the Medicaid default rate as established by New York State.

You are responsible for any in-network cost-sharing. You will be held harmless for any nonparticipating provider charges that exceed your in-network cost-sharing. The nonparticipating provider may only bill you for your in-network cost-sharing. If you receive a bill from a nonparticipating provider that is more than your in-network cost-sharing, you should contact us.

B. Urgent care
Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent care is typically available after normal business hours, including evenings and weekends. If you need care after normal business hours, including evenings, weekends, or holidays, you have options. You can call your provider's office for instructions or visit an urgent care center. If you have an emergency condition, seek immediate care at the nearest hospital emergency department, or call 911. Urgent care is covered in our service area.

1. In-Network
We cover urgent care from a participating provider or a participating urgent care center. You do not need to contact us prior to or after your visit.

2. Out-of-Network
We cover urgent care from a nonparticipating urgent care center or physician outside our service area. We require a preauthorization.

If urgent care results in an emergency admission, please follow the instructions for

emergency hospital admissions described above.

SECTION IX - OUTPATIENT AND PROFESSIONAL SERVICES

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization requirements that apply to these benefits.

A. Advanced imaging services
We cover PET scans, MRI, nuclear medicine, and CAT scans.

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

C. Ambulatory surgical center services
We cover surgical procedures performed at ambulatory surgical centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy and immunotherapy
We cover chemotherapy and immunotherapy in an outpatient facility or in a healthcare professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are covered under the **Prescription drug coverage** section of this contract.

E. Chiropractic services
We cover chiropractic care when performed by a doctor of chiropractic (chiropractor) in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of the vertebral column. This includes assessment, manipulation, and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this contract.

F. Clinical trials
We cover the routine patient costs for your participation in an approved clinical trial and such coverage shall not be subject to utilization review if you are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition.
- 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 another life-threatening disease or condition, may be subject to the **Utilization review** and **External appeal** sections of this contract.

We do not cover:

- The costs of the investigational drugs or devices.

- The costs of non-health services required for you to receive the treatment.
- The costs of managing the research.
- Costs that would not be covered under this contract 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.
- A drug trial that is exempt from having to make an investigational new drug application.

G. Dialysis
We cover dialysis treatments of an acute or chronic kidney ailment.

We also cover dialysis treatments provided by a nonparticipating provider subject to all the following conditions:
- The nonparticipating provider is duly licensed to practice and authorized to provide such treatment.
- The nonparticipating 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 nonparticipating provider is necessary.
- You notify us in writing at least 30 days in advance of the proposed treatment dates and include the written order referred to above. The 30-day advance notice period may be shortened when you need to travel on sudden notice due to a family or other emergency, provided that we have a reasonable opportunity to review your travel and treatment plans.
- We have the right to preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a nonparticipating provider per calendar year.
- Benefits for services of a nonparticipating 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 nonparticipating provider's charge.

H. Habilitation services
We cover habilitation services consisting of physical therapy, speech therapy, and occupational therapy in the outpatient department of a facility or in a healthcare professional's office.

I. Home healthcare
We cover care provided in your home by a home health agency certified or licensed by the appropriate state agency. The care must be provided pursuant to your provider'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.
- Medical supplies, prescription drugs, and medications prescribed by a provider 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 healthcare is limited to 40 visits per plan year. Each visit by a member of the home health agency is considered one visit. Each visit of up to four hours by a home health aide is considered one visit. Any rehabilitation services or habilitation services received under this benefit will not reduce the amount of services available under the rehabilitation services or habilitation services benefits.

J. Infertility treatment
We cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or the therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a member's medical history or physical findings.

Such coverage is available as follows:

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

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

Additional tests may be covered if the tests are determined to be medically necessary.

2. Comprehensive infertility services. If the basic infertility services do not result in increased fertility, we cover comprehensive infertility services. Comprehensive infertility services include:
- Ovulation induction and monitoring

- Pelvic ultrasound
- Artificial insemination
- Hysteroscopy
- Laparoscopy
- Laparotomy

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

4. Exclusions and limitations. We do not cover:
- In vitro fertilization.
- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers.
- Costs associated with an ovum or sperm donor, including the donor's medical expenses.
- Cryopreservatin and storage of sperm and ova, except when performed as fertility preservation services.
- Cryopreservation and storage of embryos.
- Ovulation predictor kits.
- Reversal of tubal ligations.
- Reversal of vasectomies.
- Costs for and relating to surrogate motherhood.
- Cloning.
- Medical and surgical procedures that are experimental or investigational, unless our denial is overturned by an external appeal agent.

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

K. Infusion therapy
We cover infusion therapy, which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a physician or other authorized healthcare 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 healthcare visit limit.

L. Interruption of pregnancy
We cover medically necessary abortions including abortions in cases of rape, incest, or fetal malformation. We cover elective abortions for one procedure per member, per plan year.

M. Laboratory procedures, diagnostic testing, and radiology services
We cover X-ray, laboratory procedures and diagnostic testing, services, and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and newborn care
We cover services for maternity care provided by a physician or midwife, nurse practitioner, hospital, or birthing center. We cover prenatal care (including one visit for genetic testing), postpartum care, delivery, and complications of pregnancy. In order for services of a midwife to be covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law, and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a physician. See the **Inpatient services** section of this contract for coverage of inpatient maternity care.

We cover breastfeeding support, counseling, and supplies, including the cost of renting or the purchase of one standard breast pump per pregnancy for the duration of breastfeeding from a participating provider or designated vendor.

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

P. Outpatient hospital service
We cover hospital services and supplies as described in the **Inpatient services** section of this contract that can be provided to you while being treated in an outpatient facility. For example, covered services include but are not limited to, inhalation therapy, pulmonary rehabilitation, infusion therapy, and cardiac rehabilitation. Unless you are receiving preadmission testing, hospitals are not participating providers for outpatient laboratory procedures and tests.

Q. Preadmission testing
We cover preadmission testing ordered by your physician and performed in hospital outpatient facilities prior to a scheduled surgery in the same hospital provided that:
- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed.
- Reservations for a hospital bed and operating room were made prior to the performance of the tests.
- Surgery takes place within seven days of the tests.
- The patient is physically present at the hospital for the tests.

R. Prescription drugs for use in the office and outpatient facilities
We cover prescription drugs (excluding self-injectables) used by your provider in the provider's office for preventive and therapeutic purposes. This benefit applies when your provider orders the prescription drug and administers it to you. When prescription drugs are covered under this benefit, they will not be covered under the Prescription drug coverage section of this contract.

S. Rehabilitation services
We cover rehabilitation services consisting of physical therapy, speech therapy, and occupational therapy in the outpatient department of a facility or in a healthcare professional's office.

We cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of your illness or injury.
- The therapy is ordered by a physician.
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered rehabilitation services must begin within six months of the following 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
- The date outpatient surgical care is rendered

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

T. Retail health clinics
We cover basic healthcare services provided to you on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered services are typically provided by a physician's assistant or nurse practitioner. Covered services available at retail health clinics are limited to routine care and treatment of common illnesses.

U. Second opinions
1. Second cancer opinion
We cover a second medical opinion by an appropriate specialist, including, but not limited to, a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a nonparticipating provider on an in-network basis when your attending physician provides a written preauthorization to a nonparticipating specialist.

2. Second surgical opinion
We cover a second surgical opinion by a qualified provider on the need for surgery.

3. Required second surgical opinion
We may require a second opinion before we preauthorize a surgical procedure. There is no cost to you when we request a second opinion.
- The second opinion must be given by a board-certified specialist who personally examines you.
- If the first and second opinions do not agree, you may obtain a third opinion.
- The second and third surgical opinion consultants may not perform the surgery on you.

4. Second opinions in other cases

There may be other instances when you will disagree with a provider's recommended course of treatment. In such cases, you may request that we designate another provider to render a second opinion. If the first and second opinions do not agree, we will designate another provider to render a third opinion. After completion of the second opinion process, we will preauthorize covered services supported by a majority of the providers reviewing your case.

V. Surgical services

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

Sometimes, two or more surgical procedures can be performed during the same operation.

- **Through the same incision.** If covered multiple surgical procedures are performed through the same incision, we will pay for the procedure with the highest allowed amount and 50 percent of the amount we would otherwise pay under this contract for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.
- **Through different incisions.** If covered multiple surgical procedures are performed during the same operative session, but through different incisions, we will pay:
  - For the procedure with the highest allowed amount.
  - 50 percent of the amount we would otherwise pay for the other procedures.

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.
- 50 percent of the amount we would otherwise pay for the other procedures.

W. Oral surgery

We cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jawbones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that is 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 jawbones 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
We cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by you and your attending physician to be appropriate. We also cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other reconstructive and corrective surgery
We cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:
- Performed to correct a congenital birth defect of a covered child which has resulted in a functional defect.
- Incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part.
- Otherwise medically necessary.

Z. Telemedicine program
We cover online internet consultations between you and providers who participate in our telemedicine program for medical conditions that are not an emergency condition. Not all participating providers participate in our telemedicine program. You can check our provider directory or contact us for a listing of the providers that participate in our telemedicine program.

AA. Transplants
We cover only those transplants determined to be non-experimental and non-investigational. Cover transplants include but are not limited to: kidney, corneal, liver, heart, heart/lung, and bone marrow transplants.

All transplants must be prescribed by your specialists. Additionally, all transplants must be performed at hospitals that we have specifically approved and designated as Centers of Excellence to perform these procedures.

We cover the hospital and medical expenses, including donor search fees, of the subscriber/recipient. We cover transplant services required by you when you serve as an organ donor only if the recipient is covered by us. We do not cover the medical expenses of a non-covered individual acting as a donor for you if the non-covered individual's expenses will be covered under another health plan or program.

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

SECTION X - ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization or preauthorization requirements that apply to these benefits.

A. Diabetic equipment, supplies, and self-management education
We cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a physician or other licensed healthcare professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. Equipment and supplies
We cover the following equipment and related supplies for the treatment of diabetes when prescribed by your physician or other provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral antidiabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall

designate by regulation as appropriate for the treatment of diabetes

Diabetic equipment and supplies are covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with us to provide all diabetic equipment or supplies required by law for members through participating pharmacies. If you require a certain item not available from our designated diabetic equipment or supply manufacturer, you or your provider must submit a request for a medical exception by calling 800-300-8181 (TTY 711). Our medical director will make all medical exception determinations. Diabetic equipment and supplies are limited to a 30-day supply up to a maximum of a 90-day supply when purchased.

2. Self-management education

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

- By a physician, other healthcare provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit
- Upon the preauthorization of your physician or other healthcare 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
- Education will also be provided in your home when medically necessary

3. Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the physician for you. We cover only basic models of blood glucose monitors unless you have special needs relating to poor vision or blindness, or if the monitor is otherwise medically necessary.

Step therapy for diabetes equipment and supplies

Step therapy is a program that requires you to try one type of diabetic prescription drug, supply, or equipment unless another prescription drug, supply, or equipment is medically necessary. The diabetic prescription drugs, supplies, and equipment that are subject to step therapy include:

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

These items also require preauthorization and will be reviewed for medical necessity. For diabetic prescription drugs, refer to the step therapy provisions in the **Prescription drug** section and the step therapy protocol override determination provisions in the **Utilization review** section of this contract.

B. Durable medical equipment and braces
We cover the rental or purchase of durable medical equipment and braces.

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

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

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

2. Braces
We cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease, or defect. Coverage is for standard equipment only. We cover replacements when growth or a change in your medical condition make replacement necessary. We do not cover the cost of repair or replacement that is the result of misuse or abuse by you.

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

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

2. Cochlear implants
We cover bone-anchored hearing aids (i.e., cochlear implants) when they are medically necessary to correct a hearing impairment. Examples of when bone-anchored hearing aids are medically necessary include the following:
- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Coverage is provided for one hearing aid per ear, per lifetime. We cover repair and/or replacement of a bone-anchored hearing aid only for malfunctions.

D. Hospice
Hospice care is available if your primary attending physician has certified that you have six months or less to live. We cover inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of hospice care.

We cover hospice care only when provided as part of a hospice care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

E. Medical supplies
We cover medical supplies that are required for the treatment of a disease or injury which is covered under this contract. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under this contract. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies. See the **Diabetic equipment, supplies, and self-management education** section above for a description of diabetic supply coverage.

F. Prosthetics
1. External prosthetic devices
We cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We cover wigs only when you have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not cover wigs made from human hair unless you are allergic to all synthetic wig materials.

We do not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not covered under this section of the contract and are only covered under the **Vision services** section of this contract.

We do not cover shoe inserts.

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

Coverage is for standard equipment only.

We cover the cost of one prosthetic device, per limb, per lifetime. We also cover the cost of repair and replacement of the prosthetic device and its parts. We do not cover the cost of repair or replacement under warranty, or if the repair or replacement is the result of misuse or abuse by you.

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

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

Coverage is for standard equipment only.

SECTION XI - INPATIENT SERVICES

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization requirements that apply to these benefits.

A. Hospital services
We cover inpatient hospital services for acute care or treatment given or ordered by a healthcare professional for an illness, injury, or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board.
- General, special, and critical nursing care.
- Meals and special diets.
- The use of operating, recovery, and cystoscopic rooms and equipment.
- The use of intensive care, special care, or cardiac care units and equipment.
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations, and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital.
- Dressing casts.
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, and 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.
- Any additional medical services and supplies which are provided while you are a registered bed patient and which are billed by the hospital.

The cost-sharing requirements in the **Schedule of benefits** section of this contract apply to a continuous hospital confinement, which is consecutive days of in-hospital service received as an inpatient or successive confinements when discharge from and readmission to the hospital that occur within a period of not more than 90 days for the same or related causes.

B. Observation services
We cover observation services in a hospital. Observation services are hospital outpatient services provided to help a physician decide whether to admit or discharge you. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient medical services
We cover medical visits by a healthcare professional on any day of inpatient care covered under this contract.

D. Inpatient stay for maternity care

We cover inpatient maternity care in a hospital for the mother, and inpatient newborn care in a hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a cesarean section delivery, regardless of whether such care is medically necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also cover any additional days of such care that we determine are medically necessary. In the event the mother elects to leave the hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, we will cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our coverage of this home care visit shall be in addition to home healthcare visits under this contract and shall not be subject to any cost-sharing amounts in the **Schedule of benefits** section of this contract that apply to home care benefits.

We also cover the inpatient use of pasteurized donor human milk, which may include fortifiers as medically necessary, for which a healthcare professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breastfeeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breastfeeding despite optimal lactation support. Such infant must have a documented birth weight of less than 1,500 grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient stay for mastectomy care
We cover inpatient services for subscribers undergoing a lymph node dissection, lumpectomy, mastectomy, or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by you and your attending physician.

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

G. Habilitation services
We cover inpatient habilitation services consisting of physical therapy, speech therapy, and occupational therapy.

H. Rehabilitation services
We cover inpatient rehabilitation services consisting of physical therapy, speech therapy, and occupational therapy.

We cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of your illness or injury;
- The therapy is ordered by a physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered rehabilitation services must begin within six 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.

I. Skilled nursing facility

We cover services provided in a skilled nursing facility, including care and treatment in a semi-private room, as described in the **Hospital services** section above. Custodial, convalescent, or domiciliary care is not covered (see the **Exclusions and limitations** section of this contract). An admission to a skilled nursing facility must be supported by a treatment plan prepared by your provider and approved by us. We cover up to 200 days per plan year for noncustodial care.

J. End of life care

If you are diagnosed with advanced cancer and you have fewer than 60 days to live, we will cover acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients. Your attending physician and the facility's medical director must agree that your care will be appropriately provided at the facility. If we disagree with your admission to the facility, we have the right to initiate an expedited external appeal to an external appeal agent. We will cover and reimburse the facility for your care, subject to any applicable limitations in this contract until the external appeal agent renders a decision in our favor.

We will reimburse nonparticipating 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 percent of the appropriate Medicare acute care rate.

K. Limitations/terms of coverage

- We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is medically necessary), or medications and supplies you take home from the facility. If you occupy a private room, and the private room is not medically necessary, our coverage will be based on the facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
- We do not cover radio, telephone or television expenses, or beauty or barber services.
- We do not cover any charges incurred after the day we advise you it is no longer medically necessary for you to receive inpatient care, unless our denial is overturned by an external appeal agent.

SECTION XII - MENTAL HEALTHCARE AND SUBSTANCE USE SERVICES

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization or preauthorization requirements that apply to these benefits, which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental healthcare services. We cover the following mental healthcare services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. Inpatient services

We cover inpatient mental healthcare services relating to the diagnosis and treatment of mental health conditions comparable to other similar hospital, medical, and surgical coverage provided under this contract. Coverage for inpatient services for mental healthcare 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 healthcare 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 healthcare that has been issued an operating certificate by the New York State Commissioner of Mental Health.

And, in other states, to similarly licensed or certified facilities. In the absence of a similarly licensed or certified facility, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by us.

We also cover inpatient mental healthcare services relating to the diagnosis and treatment of mental health conditions received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified facility, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by us.

2. Outpatient services

We cover outpatient mental healthcare services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. We cover up to a total of 20 family counseling visits during a Plan

Year. Family counseling includes family counseling visits with the enrollee present and family counseling visits without the enrollee present. Coverage for outpatient services for mental healthcare includes facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified facility, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by us. Outpatient services also include nutritional counseling to treat a mental health condition.

3. Autism spectrum disorder

We cover the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be medically necessary for the screening, diagnosis, 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.

i. Screening and diagnosis

We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

ii. Assistive communication devices

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

We cover repair, replacement fitting, and adjustments of such devices when made necessary by normal wear and tear or significant change in your physical condition. We do not cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, we cover one repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to your current functional level. We do not cover delivery or service charges or routine maintenance.

iii. Behavioral health treatment

We cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We cover applied behavior analysis when provided by a licensed or certified applied behavior analysis healthcare 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.

iv. Psychiatric and psychological care

We cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

v. Therapeutic care

We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this contract.

vi. Pharmacy care

We cover prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under this contract.

vii. Limitations

We do not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this contract for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

You are responsible for any applicable copayment or coinsurance provisions under this contract for similar services. For example, any copayment or coinsurance that applies to physical therapy

visits will generally also apply to physical therapy services covered under this benefit; and any copayment or coinsurance for prescription drugs will generally also apply to prescription drugs covered under this benefit. See the **Schedule of benefits** section of this contract for the cost-sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance use services. We cover the following substance use services to treat a substance use disorder. For purpose of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. Inpatient services

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

We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is facilities that are licensed, certified, or otherwise authorized by OASAS; and, in other states, to those facilities that are licensed, certified, or otherwise authorized by a similar state agency and are accredited by the Joint Commission or a national accreditation organization recognized by us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. Outpatient services

We cover outpatient substance use services relating to the diagnosis and treatment substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such coverage is limited to facilities in New York State that are licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by us as alcoholism, substance abuse, or chemical dependence treatment programs. Coverage in an OASAS-certified facility includes services provided by an OASAS credentialed provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use, and dependency, or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV, and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.

SECTION XIII - PRESCRIPTION DRUG COVERAGE

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization or preauthorization requirements that apply to these benefits.

A. Covered prescription drugs

We cover medically necessary prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription."
- FDA approved.
- Ordered by a provider authorized to prescribe and within the provider's scope of practice.
- Prescribed within the approved FDA administration and dosing guidelines.
- 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.
- Prenatal 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.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.
- Prescription or nonprescription enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed provider has issued a written order. The written order must state that the enteral formula is medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and non-immunoglobulin E medicated allergies to multiple food proteins; severe protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription drugs prescribed in conjunction with treatment or services covered under the infertility treatment benefit in the **Outpatient and professional services** section of this contract.

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

You may request a copy of our Formulary. Our Formulary is also available on our website at empireblue.com/nyessentialplan. You may inquire if a specific drug is covered under this contract by contacting us at 800-300-8181 (TTY 711).

B. Refills

We cover refills of prescription drugs only when dispensed at a retail or mail-order pharmacy as ordered by an authorized provider. Benefits for refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, we allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals. To the extent practicable, the quantity of eye drops in the early refill will be limited to the amount remaining on the dosage that was initially dispensed. Your cost sharing for the limited refill is the amount that applies to each prescription or refill as set forth in the **Schedule of benefits** section of this contract.

C. Benefit and payment information

1. Cost-sharing expenses

You are responsible for paying the costs outlined in the **Schedule of benefits** section of this contract when covered prescription drugs are obtained from a retail pharmacy.

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

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 participating pharmacy, you are responsible for paying the lower of:

- The applicable cost sharing;
- The prescription drug cost for that prescription drug; or
- Your cost sharing will never exceed the usual and customary charge of the prescription drug.

3. Nonparticipating pharmacies

We will not pay for any prescription drugs that you purchase at a nonparticipating retail or mail-order pharmacy.

4. Mail order

Certain prescription drugs may be ordered through our mail-order pharmacy after an initial 30-day supply, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply. You are responsible for paying the lower of:

- The applicable cost sharing.
- The cost for that prescription drug.

Your cost sharing will never exceed the usual, customary, and reasonable change 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 may be charged the mail-order cost sharing for any prescription orders or refills sent to the mail- order supplier regardless of the number of days' supply written on the prescription order or refill.

Prescription drugs purchased through mail order will be delivered directly to your home or office.

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

You or your provider may obtain a copy of the list of prescription drugs available through mail order by visiting our website at empireblue.com/nyessentialplan or by calling 800-300-8181 (TTY 711).

5. Tier status

The tier status of a prescription drug may change periodically, but no more than four times per calendar year, or when a brand-name drug becomes available as a generic drug as described below, based on our tiering decisions. These changes may occur without prior notice to you. However, if you have a prescription for a drug that is being moved to a higher tier or is being removed from our formulary, we will notify you at least 30 days before the change is effective. When such changes occur, your cost sharing may change. You may also request a formulary exception for a prescription drug that is no longer of the formulary as outlined below and in the **External appeal** section of this contract. You may access the most up-to-date tier status on our website at empireblue.com/nyessentialplan or by calling 800-300-8181 (TTY 711).

6. When a brand-name drug becomes available as a generic drug

When a brand-name drug becomes available as generic drug, the tier placement of the brand-name prescription drug may change. If this happens, you will pay the cost sharing applicable to the tier to which the prescription drug is assigned or the brand-name drug will be removed from the formulary and you no longer have benefits for that particular brand-name drug. Please note, if you are taking a brand-name drug that is being excluded or placed on a higher tier due to a generic drug becoming available, you will receive 30 days' advance written notice of the change before it is effective. You may request a formulary exception for a prescription drug that is no longer on the formulary as outlined below and in the **External appeal** section of this contract.

7. Formulary exception process

If a prescription drug is not on our formulary, you, your designee, or your prescribing healthcare 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 healthcare provider that all Formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. If coverage is denied under our standard or expedited Formulary exception process, you are entitled to an external appeal as outlined in the **External appeal** section of this contract. Visit our website at empireblue.com/nyessentialplan or call 800-300-8181 (TTY 711) 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 healthcare provider by telephone and in writing no later than 72 hours after our receipt of your request. If we approve the request, we will cover the prescription drug while you are taking the prescription drug, including any refills.

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 healthcare 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 healthcare provider by telephone and in writing no later than 24 hours after our receipt of your request. If we approve the request, we will cover the prescription drug while you suffer from the health condition that may seriously jeopardize your health, life, or ability to regain maximum function or for the duration of your current course of treatment using the non-formulary prescription drug.

8. Supply limits

Except for contraceptive drugs, devices or products, we will pay for no more than a 30-day supply of a prescription drug purchased at a retail pharmacy. You are responsible for one cost-sharing amount, for up to a 30-day supply.

You may have the entire supply (of up to 12 months) of a prescribed contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to cost sharing when provided by a participating pharmacy.

Benefits will be provided for prescription drugs dispensed by a mail-order pharmacy in a quantity of up to a 90-day supply. You are responsible for two and a half (2.5) cost-sharing amounts for a 90-day supply.

Specialty prescription drugs may be limited to a 30-day supply when obtained at a network specialty pharmacy. You may access our website empireblue.com/nyessentialplan or by calling 800-300-8181 (TTY 711) 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 empireblue.com/nyessentialplan or by calling 800-300-8181 (TTY 711). If we deny a request to cover an amount that exceeds our quantity level, you are entitled to an appeal pursuant to the **Utilization review** and **External appeal** sections of this contract.

9. Initial limited supply of prescription opioid drugs

If you receive an initial limited prescription for a seven-day supply or less of any schedule II, III, or IV opioid prescribed for acute pain, and you have a copay, your copay will be prorated. If you receive an additional supply of the prescription drug within the 30-day period in which you received the seven-day supply, your copay for the remainder of the 30-day supply will also be prorated. In no event will the prorated copays total more than your copay for a 30-day supply.

10. Cost sharing for orally-administered anti-cancer drugs

Your cost sharing for orally-administered anti-cancer drugs is the cost-sharing amount specified in the **Schedule of benefits** section of this contract or the cost-sharing amount, if any, that applies to intravenous or injected anticancer medications covered under the **Outpatient and professional services** section of this contract.

D. Medical management

This contract includes certain features to determine when prescription drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before we can decide if the prescription drug is medically necessary.

1. Preauthorization

Preauthorization may be needed for certain prescription drugs to make sure proper use and guidelines for Prescription drug coverage are followed. When appropriate, your provider will be responsible for obtaining preauthorization for the prescription drug. Preauthorization is not required for covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to you.

For a list of prescription drugs that need preauthorization, please visit our website at empireblue.com/nyessentialplan or call 800-300-8181 (TTY 711). 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 that undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a prescription drug or related item on the list is not covered under your contract. Your provider may check with us to find out which prescription drugs are covered.

2. Step therapy

Step therapy is a process in which you may need to use one or more types of prescription drug before we will cover another as medically necessary. A "step therapy protocol" means our policy, protocol, or program that established the sequence in which we approve prescription drugs for your medical condition. When establishing a step therapy protocol, we will use recognized, evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain prescription drugs to make sure proper prescribing guidelines are followed. These guidelines help you receive high-quality and cost-effective prescription drugs. The prescription drugs that require preauthorization under the step therapy program are also included on the preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a prescription drug, you, your designee, or your healthcare professional can request a step therapy override determination as outlined in the **Utilization review** and **External appeal** sections of this contract.

3. Therapeutic substitution

Therapeutic substitution is an optional program that tells you and your providers about alternatives to certain prescribed drugs. We may contact you and your provider to make you aware of these choices. Only you and your provider can determine if the therapeutic substitute is right for you. We have a therapeutic drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic drug substitutes, visit our website at empireblue.com/nyessentialplan or call 800-300-8181 (TTY 711).

E. Limitations/terms of coverage

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.

1. If we determine that you may be using a prescription drug in a harmful or abusive manner, or with harmful frequency, your selection of participating pharmacies and prescribing providers may be limited. If this happens, we may require you to select a single participating pharmacy and a single provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if your prescription orders or refills are written by the selected provider or a provider authorized by your selected provider. If you do not make a selection within 31 days of the date we notify you, we will select a single participating pharmacy and/or prescribing provider for you.

2. Compounded prescription drugs will be covered only when ingredients are included on the formulary, and are obtained from a pharmacy that is approved for compounding. All compounded prescription drugs over $200 require your provider to obtain preauthorization.

3. 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 drugs affected by the protocol, you will be notified in advance.

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

5. We do not cover charges for the administration or injection of any prescription drug. Prescription drugs given or administered in a physician's office are covered under the **Outpatient and professional services** section of this contract.

6. We do not cover drugs that do not by law require a prescription, except for smoking-cessation drugs, over-the-counter preventive drugs, or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this contract. We do not cover prescription drugs that have over-the-counter nonprescription equivalents, except if specifically designated as covered in the drug Formulary, or as otherwise stated in this contract. Nonprescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not cover repackaged products such as therapeutic kits or convenience packs that contain a covered prescription drug unless the prescription drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more prescription drugs and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes, or topical emollients.

7. We do not cover prescription drugs to replace those that may have been lost or stolen.

8. We do not cover prescription drugs dispensed to you while in a hospital, nursing home, other institution, facility, or if you are a home care patient, except in those cases where the basis of

payment by or on behalf of you to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.

9. We reserve the right to deny benefits as not medically necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, you are entitled to an appeal as described in the **Utilization review** and **External appeal** sections of this contract.

10. A pharmacy need not dispense a prescription order that, in the pharmacist's professional judgment, should not be filled.

F. General conditions

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.

1. **Drug utilization, cost management, and rebates.** We conduct various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for your coverage. We may also, from time to time, enter into agreements that result in us receiving rebates or other funds (rebates) directly or indirectly from prescription drug manufacturers, prescription drug distributors, or others. Any rebates are based upon utilization of prescription drugs across all of our business and not solely on any one member's utilization of prescription drugs. Any rebates received by us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of our prescription drug premiums. Any such rebates may be retained by us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities, and increasing reserves for the protection of members. Rebates will not change or reduce the amount of any copayment or coinsurance applicable under our Prescription drug coverage.

G. Definitions

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

1. Brand-name drug: A prescription drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) we identify as a brand-name prescription drug, based on available data resources. All prescription drugs identified as "brand name" by the manufacturer, pharmacy, or your physician may not be classified as a brand-name drug by us.

2. **Designated pharmacy:** A pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific prescription drugs, including, but

not limited to, specialty prescription drugs. The fact that a pharmacy is a participating pharmacy does not mean that it is a designated pharmacy.

3. **Formulary:** The list that identifies those prescription drugs for which coverage may be available under this contract. This list is subject to our periodic review and modification (no more than four times per calendar year or when a brand-name drug becomes available as a generic drug). To determine to which tier a particular prescription drug has been assigned, visit our website at empireblue.com/nyessentialplan or call 800-300-8181 (TTY 711).

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. **Nonparticipating pharmacy:** A pharmacy that has not entered into an agreement with us to provide prescription drugs to subscribers. We will not make any payment for prescriptions or refills filled at a nonparticipating 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.
    - 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 nonskilled caregiver.

8. **Prescription drug cost:** The rate we have agreed to pay our participating pharmacies, including a dispensing fee and any sales tax, for a covered prescription drug dispensed at a participating pharmacy. If your contract includes coverage at nonparticipating pharmacies, the prescription drug cost for a prescription drug dispensed at a nonparticipating 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 healthcare 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 New York Education Law Section 6826-a.

SECTION XIV – WELLNESS BENEFITS

A. Exercise facility reimbursement
We will partially reimburse (repay) you each benefit plan year for your fitness center's membership dues. You'll be reimbursed the lesser of $200 or the actual cost of the membership per six-month period (up to $100 each six-month period).

Just follow these steps to qualify:
1. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year, which is the 12-month period of coverage that starts on your effective date of coverage.
   - This reimbursement program is based on two six-month periods within your benefit plan year. For example, if your effective date is January 1, 2021, the first six-month period is from January 1, 2021 – June 30, 2021. The second six-month period is from July 1, 2021 – December 21, 2021.
2. Exercise once during a 24-hour period. There must be at least eight hours between workouts (but no more than one per calendar day).
3. Choose how you select your fitness center and manage your gym reimbursement:
   - **Choice one**: Go to a qualifying fitness center, track your workouts, and send in your completed Fitness Center Membership Verification (FCMV) and Gym Reimbursement forms. A qualifying fitness center:
     - Is in the U.S. and open to the public.
     - Has staff oversight. Staff oversight means that, during normal operational hours, the fitness center has employees who oversee operations and attend to members. Class instructors don't constitute oversight.
     - Offers regular cardio, flexibility, and/or weight-training programs.

     Also see the **Exclusions and limitations** heading below.
   - **Choice two**: Enroll in the Active&Fit Direct™ (AFD) program through exciserewards.com. Once enrolled, AFD automatically tracks your visits and manages your reimbursement paperwork for you.

Visit exciserewards.com for additional details about the reimbursement program. You can also download forms, view fitness center options, and learn how to manage your gym reimbursement. For questions, visit exciserewards.com or call Member Services at 800-300-8181 (TTY 711).

How to be reimbursed for your fitness center membership dues
Note: If you're enrolled in the AFD program, **you don't need to submit anything** for reimbursement.

After each six-month period or when you've completed 50 workouts, you can be reimbursed by:
- **Filling out** the Gym Reimbursement form.
- **Providing your fitness log with tracked workouts.**
  - Use your fitness center's computer printouts, if offered. Attach the printouts to your completed Gym Reimbursement form.

- Fill out the fitness log on the back of the Gym Reimbursement form. A fitness center staff member needs to sign or stamp your log sheet after each workout.
- **Attaching a receipt or credit card statement (if you have automatic billing)** that shows you paid for the fitness center membership for the time frame you're requesting reimbursement.
- **Including a signed copy of the FCMV form**. This form needs to be submitted with your first reimbursement request and/or once per benefit plan year for each qualifying fitness center. *The FCMV form must also be signed by a fitness center representative.*

Note: Gym Reimbursement and FCMV forms are available for download at exerciserewards.com.

- **You can send us your documents in two ways:**
  - Email: **fitness@exerciserewards.com**
    Use subject line: Gym Reimbursement Request.
    Include electronic and scanned copies as attachments.
  - Send printed copies to:
    The ExerciseRewards™ Program
    P.O. Box 509117
    San Diego, CA 92150-9117

If you request reimbursement before the end of the six-month period because you have met 50 visits and your reimbursement request does not meet your reimbursement maximum, you can continue to submit for reimbursement until the end of the six-month period, up to the annual reimbursement maximum. Reimbursement must be requested within 120 days after the end of the benefit plan year.

Visit exerciserewards.com for full details on the exercise facility reimbursement process and requirements.

Receiving your reimbursement
Your reimbursement will generally be processed within 30 days of receipt of your completed documents once the payout period ends.

Exclusions and limitations
Please note the following about the Gym Reimbursement Program:
- Members younger than 19 do not qualify for reimbursement.
- The following services and activities don't qualify: rehabilitation services, physical therapy services, country clubs, social clubs, and sports teams or leagues.
- Fees or dues for taking part in aerobic/fitness activities in clubs or centers that don't qualify, as well as fees for personal training, lessons, such as for tennis and swimming, courses (including boot camp), homeowner's association (HOA) fees, coaching, and exercise equipment or clothing purchases, aren't eligible for reimbursement.
- Exercise sessions at fitness centers where a membership or class agreement isn't offered or there is no staff oversight don't qualify.

- Reimbursements are based on the membership fees that are paid by a member up to the annual contract maximum reimbursement amount.
- Reimbursement is made based on the order of submitted requests until the maximum amount is reached.
- You won't be reimbursed for months during which services haven't yet been provided. If you submit requests for such months, reimbursement will be denied and you'll need to submit a new request for reimbursement once the services have been provided.
- Exercise sessions before you became eligible for the Gym Reimbursement Program do not qualify.
- Reimbursement requests received later than 120 days after the end of your benefit plan year don't qualify.

B. Wellness program

1. Purpose

The purpose of this wellness program is to encourage you to take a more active role in managing your health and well-being.

2. Description

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

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

3. Eligibility

You, the subscriber, can participate in the wellness program.

4. Participation

The preferred method for accessing the wellness program is through our website at empireblue.com/nyessentialplan. You need to have access to a computer with internet access in order to participate in the website program. However, if you do not have access to a computer, please call us at 800-300-8181 (TTY 711) and we will provide you with information regarding how to participate without internet access.

5. Rewards

Rewards for participation in a wellness program include:

- Full or partial reimbursement of the cost of participating in smoking-cessation or weight management programs.

- Full or partial reimbursement of the cost of membership in a health club or fitness center. You'll be reimbursed the lesser of $200 or the actual cost of the membership per six-month period.
- The waiver or reduction of copays, deductibles, or coinsurance.
- Contributions to a health reimbursement account (HRA) or health savings account (HSA).
- Monetary rewards in the form of cash, gift cards, or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins, or exercise equipment.
- Merchandise, so long as the item is geared at promoting good health, such as healthy cookbooks or nutritional or exercise equipment.

SECTION XV – DISEASE MANAGEMENT PROGRAM

Disease Management
A Disease Management (DM) program can help you receive more out of life. As part of your Empire benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

Our team includes registered nurses called DM case managers. They'll help you learn how to better manage your condition, or health issue. You can choose to join a DM program at no cost to you.

What programs do we offer?
You can join a Disease Management program to receive healthcare and support services if you have any of these conditions:

Asthma	Major Depressive Disorder – Adult
Bipolar Disorder	Major Depressive Disorder – Child and Adolescent
Chronic Obstructive Pulmonary Disease (COPD)	Schizophrenia
Congestive Heart Failure (CHF)	Coronary Artery Disease (CAD)
HIV/AIDS	Diabetes
Hypertension	Substance Use Disorder

How it works
When you join one of our DM programs, a DM case manager will:
- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your healthcare providers, like helping you with:
  - Making appointments.
  - Getting to healthcare provider visits.
  - Referring you to specialists in our health plan, if needed.
  - Receiving any medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco like quitting smoking).

Our DM team and your primary care provider (PCP) are here to help you with your healthcare needs.

How to join
We'll send you a letter welcoming you to a DM program, if you qualify. Or, call us toll free at 888-830-4300 (TTY 711) Monday through Friday from 8:30 a.m. to 5:30 p.m. local time.

When you call, we'll:

- Set you up with a DM case manager to begin.
- Ask you some questions about your or your child's health.
- Start working together to create your or your child's plan.

You can also email us at dmself-referral@empireblue.com. Please be aware that emails sent over the internet are usually safe, but there is some risk third parties may access (or receive) these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out (we'll take you out of the program) of the program at any time. Please call us toll free at 888-830-4300 (TTY 711) from 8:30 a.m. to 5:30 p.m. local time Monday through Friday to opt out. You may also call this number to leave a private message for your DM case manager 24 hours a day.

Useful phone numbers

In an emergency, call 911.

Disease Management
Toll free: 888-830-4300 (TTY 711)
Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call the 24/7 NurseLine
24 hours a day, seven days a week
800-300-8181 (TTY 711)

Disease Management rights and responsibilities

When you join a Disease Management program, you have certain rights and responsibilities. You have the right to:

- Receive details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of DM services.
- Know which DM case manager is handling your DM services and how to ask for a change.
- Receive support from us to make healthcare choices with your healthcare providers.
- Ask about all DM-related treatment options (choices of ways to become better) mentioned in clinical guidelines (even if a treatment is not part of your health plan), and talk about options with treating healthcare providers.
- Have personal data and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.

- Receive information that is clear and easy to understand.
- File complaints to Empire by calling 888-830-4300 (TTY 711) toll free from 8:30 a.m. to 5:30 p.m. local time Monday through Friday and:
  - Receive help on how to use the complaint process.
  - Know how much time Empire has to respond to and resolve issues of quality and complaints.
  - Give us feedback about the Disease Management program

You also have a responsibility to:

- Follow the care plan that you and your DM case manager agree on.
- Give us information needed to carry out our services.
- Tell us and your healthcare providers if you choose to opt out (leave the program).

Disease Management does not market products or services from outside companies to our members. DM does not own or profit from outside companies on the goods and services we offer.

SECTION XVI – ADDITIONAL BENEFITS FOR CERTAIN ESSENTIAL PLAN SUBSCRIBERS

Please refer to the **Schedule of benefits** section of this contract for cost-sharing requirements, day or visit limits, and any preauthorization requirements that apply to these benefits.

A. Dental services

1. **Covered dental services.** We cover regular and routine dental services such as preventive dental checkups, cleaning, X-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you.

2. **How to access dental services.** If you need to find a dentist or change your dentist, please call LIBERTY Dental Plan at 833-276-0847 (TTY 711) Monday through Friday, 8 a.m. to 8 p.m. Eastern time. Customer service representatives are there to help you. Many speak your language or have services that will translate in any language you need.

3. **Orthodontia services**. Orthodontia is covered when you have a medically necessary surgical treatment, such as reconstructive surgery of your jaw.

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

5. **Implant services.** Dental implants will be covered when medically necessary. Preauthorization requests for implants must have supporting documentation from your physician and dentist. The letter from your physician must explain how implants will alleviate your medical condition. The letter from your dentist must explain why other covered functional alternatives for prosthetic replacement will not correct your dental condition and why you require implants. Other supporting documentation for the request may be submitted including X-rays.

B. Vision Services

1. Covered vision services. We offer vision care through a contract with Superior Vision, an expert in providing high-quality vision services. We cover the following vision services:

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed

glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a participating provider;
- Eye exams, generally every two years, unless medically needed more often;
- Low-vision exam and vision aids ordered by your doctor;
- Specialist preauthorizations for eye diseases or defects.

2. How to access vision services
If you need to find a vision provider or change your vision provider, please call Superior Vision at 800-879-6901 Monday through Friday 8 a.m. to 9 p.m. Eastern time.

C. Non-prescription drugs (over-the-counter or OTC)
In addition to the Prescription drug coverage described in the **Prescription drug coverage** section of this contract, we also cover non-prescription (OTC) drugs, medical supplies, and hearing aid batteries when ordered by a licensed provider.

D. Foot care services
We cover routine foot care provided by licensed provider types other than podiatrists when your physical condition poses a hazard due to the localized presence of an illness, injury, or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections. We do not cover routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, cleaning, or soaking feet, unless you have a pathological condition that requires the services.

E. Orthopedic footwear
We cover orthopedic footwear when used to correct, accommodate, or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot, or to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. Coverage includes shoes, shoe modifications, or shoe additions. We do not cover sneakers and athletic shoes.

F. Family planning services
In addition to the family planning services described in the **Outpatient and professional services** section, you may receive certain family planning and reproductive health services either from one of our participating providers or from any appropriate Medicaid health provider of your choice. You do not need a preauthorization from your PCP to obtain these services. If you visit any appropriate Medicaid health provider, the cost to you will be the same as the cost of seeing on of our participating providers.

The following are the family planning and reproductive health services that you may receive from any Medicaid health provider or a participating provider:

1. Screening, related diagnosis, ambulatory treatment, and preauthorizations to a participating provider as needed for dysmenorrhea, cervical cancer, or other pelvic abnormalities.

2. Screening, related diagnosis, and preauthorization to participating provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, and pregnancy. HIV

testing and pre-test and post-test counseling when performed as part of a family planning visit.

3. You must visit a participating provider in order to have the following family planning and reproductive health services covered by us:

- Infertility treatment as set forth in the family planning services described in the **Outpatient and professional services** section.
- Routine gynecologic care, including hysterectomies, as set forth in the **Outpatient and professional services** section of this contract.
- Any other family planning and reproductive service not specified above.

G. Non-emergency transportation

In addition to the non-emergency ambulance transportation benefit in the **Ambulance and pre-hospital emergency services** section, you are eligible for non-emergency transportation, which includes personal vehicle, bus, taxi, ambulette, and public transportation to medical appointments. You or your provider must call the vendor listed below to arrange transportation:

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

- Putnam — 855-360-3547

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

If possible, you or your provider should call ModivCare at least three days before your medical appointment and provide your appointment date and time, its address, and the doctor you are seeing.

H. Family counseling

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

SECTION XVII – EXCLUSIONS AND LIMITATIONS

No coverage is available under this contract for the following:

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

B. Convalescent and custodial care
We do not cover services related to rest cures, custodial care, or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include covered services determined to be medically necessary.

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

D. Cosmetic services
We do not cover cosmetic services, prescription drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. We also cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this contract. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the **Utilization review** and **External appeal** sections of this contract unless medical information is submitted.

E. Coverage outside the United States, Canada, or Mexico
We do not cover care or treatment provided outside the United States, its possessions, Canada, or Mexico except for emergency services, pre-hospital emergency medical services, and ambulance services to treat your emergency condition.

F. Dental services
We do not cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, dental care or treatment necessary due to

congenital disease or anomaly, or dental care or treatment specifically stated in the **Outpatient and professional services** section of this contract. We do not cover orthodontia services except as specifically stated in the **Dental care** section of this contract.

G. Experimental or investigational treatment
We do not cover any healthcare service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial as described in the **Outpatient and professional services** section of this contract, or when our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, nonhealth services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under this contract for noninvestigational treatments. See the **Utilization review** and **External appeal** sections of this contract for a further explanation of your appeal rights.

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

I. Foot care
We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. However, we will cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

J. Government facility
We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state, or other governmental entity, except as otherwise required by law unless you are taken to the hospital because it is close to the place where you were injured or became ill and emergency services are provided to treat your emergency condition.

K. Medically necessary
In general, we will not cover any healthcare service, procedure, treatment, test, device, or prescription drug that we determine is not medically necessary. If an external appeal agent certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test, device, or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device, or prescription drug is otherwise covered under the terms of this contract.

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

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

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

O. Services not listed
We do not cover services that are not listed in this contract as being covered.

P. Services provided by a family member
We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

Q. Services separately billed by hospital employees
We do not cover services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

R. Services with no charge
We do not cover services for which no charge is normally made.

S. Vision services
We do not cover the examination or fitting of eyeglasses or contact lenses except as specifically stated in the **Vision care** section of this contract.

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

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

SECTION XVIII – CLAIM DETERMINATIONS

A. Claims
A claim is a request that benefits or services be provided or paid according to the terms of this contract. Either you or the provider must file a claim form with us. If the provider is not willing to file the claim form, you will need to file it with us.

B. Notice of claim
Claims for services must include all information designated by us as necessary to process the claim, including, but not limited to: member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from us by calling 800-300-8181 (TTY 711) or visiting our website at empireblue.com/nyessentialplan. Completed claim forms should be sent to the address on your ID card.

C. Time frame for filing claims
Claims for services must be submitted to us for payment within 120 days after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, you must submit it as soon as reasonably possible.

D. Claims for prohibited preauthorizations
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 preauthorization prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim determinations
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, our claim determination procedure applies to contractual benefit denials and preauthorizations. If you disagree with our claim determination, you may submit a grievance pursuant to the **Grievance procedures** section of this contract.

For a description of the utilization review procedures and appeal process for medical necessity or experimental or investigational determinations, see the **Utilization review** and **External appeal** sections of this contract.

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

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

2. Urgent pre-service reviews. With respect to urgent pre-service requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three 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 calendar days of the decision.

G. Post-service claim determinations

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

H. Payment of claims

Where our obligation to pay a claim is reasonably clear, we will pay the claim within 30 days of receipt of the claim when submitted through the internet or email, and 45 days of receipt of the claim when submitted through other means, including paper or fax. If we request additional information, we will pay the claim within 30 days for claims submitted through the internet or email or 45 days for claims submitted through other means, including paper or fax of receipt of the information.

SECTION XIX – GRIEVANCE PROCEDURES

A. Grievances
Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

B. Filing a grievance
You can contact us by phone at 800-300-8181 (TTY 711) (the number on your ID card) or in writing to file a grievance. You must use our grievance form for written grievances. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

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

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

C. Grievance determination
Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified, or registered healthcare professional will look into it. We will decide the grievance and notify you within the following timeframes:

Expedited/urgent grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your grievance.
Pre-service grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of your grievance.
Post-service grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of your grievance.
All other grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of your grievance, but no more than 45 calendar days of receipt of all necessary information.

D. Assistance
If you remain dissatisfied with our grievance determination, or at any other time you are dissatisfied, you may:

Call the New York State Department of Health at 800-206-8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: health.ny.gov

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

If you need assistance filing a grievance or appeal, you may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 888-614-5400
Email: cha@cssny.org
Website: communityhealthadvocates.org

SECTION XX – UTILIZATION REVIEW

A. Utilization review
We review health services to determine whether the services are or were medically necessary or experimental or investigational (medically necessary). This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call 800-300-8181 (TTY 711). 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 healthcare 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 healthcare service under review; or 3) with respect to mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered, or credentialed healthcare professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not medically necessary.

We have developed guidelines and protocols to assist us in this process. We will use evidence-based and peer reviewed clinical review criteria tools that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call 800-300-8181 (TTY 711) or visit our website at empireblue.com/nyessentialplan.

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 business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. Urgent preauthorization reviews. With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three business days of receipt of the

request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period. Written notification will be provided within the earlier of three business days of our receipt of the information or three calendar days after the verbal notification.

3. Court-ordered treatment. Effective on the date of issuance or renewal of this contract on or after April 1, 2016, with respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, we will make a determination and provide notice to you (or your designee) and your provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three business days of our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. Inpatient rehabilitation services reviews. After receiving a preauthorization request for coverage of inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of the necessary information.

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), by telephone and in writing, within one business day of receipt of all necessary information. If we need additional information, we will request it within one 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), by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 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) by telephone within 24 hours of receipt of the request. Written notice will be provided within one 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 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) within the earlier of one business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. Home healthcare reviews

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

4. Inpatient substance use disorder treatment reviews

If a request for inpatient substance use disorder treatment is submitted to us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within 24 hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.

5. Inpatient substance use disorder treatment at participating OASAS-certified facilities

Coverage for inpatient substance use disorder treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified facility notifies us of both the admission and the initial treatment plan within two business days of the admission. After the first 28 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your inpatient admission.

6. Outpatient substance use disorder treatment at participating OASAS-certified facilities

Coverage for outpatient, intensive outpatient, outpatient rehabilitation, and opioid treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 4 weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified facility notifies us of both the start of treatment and the initial treatment plan within two business days. After the first 4 weeks of continuous treatment, not to exceed 28 visits, we may review the entire outpatient treatment to determine whether it is medically necessary and we will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your outpatient treatment.

D. Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you 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 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.
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria, or procedures as used during the preauthorization review.

F. Step therapy override determinations

You, your designee, or your healthcare professional may request a step therapy protocol override determination for coverage of a prescription drug selected by your healthcare professional. When conducting utilization review for a step therapy protocol override determination, we will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for you and your medical condition.

1. Supporting rationale and documentation. A step therapy protocol override determination request should include supporting rationale and documentation from a healthcare professional, demonstrating that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to you.
- The required prescription drug is expected to be ineffective based on your known clinical history, condition, and prescription drug regimen.
- You have tried the required prescription drug while covered by us or under your previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- You are stable on a prescription drug selected by your healthcare professional for your medical condition, provided this does not prevent us from requiring you to try an AB-rated generic equivalent.
- The required prescription drug is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. Standard review. We will make a step therapy protocol override determination and provide notification to you (or your designee), and where appropriate, your healthcare professional, within 72 hours of receipt of the supporting rationale and documentation.

3. Expedited review. If you have a medical condition that places your health in serious jeopardy without the prescription drug prescribed by your healthcare professional, we will make a step therapy protocol override determination within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, we will request the information within 72 hours for preauthorization and retrospective reviews, the lesser of 72 hours or one business day for concurrent reviews, and 24 hours for expedited reviews. You or your healthcare professional will have 45 calendar days to submit the information for preauthorization, concurrent, and retrospective reviews, and 48 hours for expedited reviews. For preauthorization reviews, we will make a determination and provide notification to you (or your designee) and your healthcare professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, we will make a determination and provide notification to you (or your designee) and your healthcare professional within the earlier of 72 hours or one business day of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, we will make a determination and provide notification to you (or your designee) and your healthcare professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, we will make a determination and provide notification to you (or your designee) and your healthcare professional within the earlier of 24 hours of our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If we do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If we determine that the step therapy protocol should be overridden, we will authorize immediate coverage for the prescription drug prescribed by your treating healthcare professional. An adverse step therapy override determination is eligible for an appeal.

G. Reconsideration

If we did not attempt to consult with your provider who recommended the covered service before making an adverse determination, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination, or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

H. Utilization review internal appeals

You, your designee, and, in retrospective review cases, your provider, may request an internal appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a physician, or (2) a healthcare professional in the same or similar specialty as the provider who typically manages the disease or condition at issue.

1. **Out-of-network service denial.** You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a nonparticipating provider, but only when the service is not available from a participating provider. For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:
   - A written statement from your attending physician, who must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-network referral; authorization denial.** You also have the right to appeal the denial of a request for a referral; an authorization to a nonparticipating provider when we determine that we have a participating provider with the appropriate training and experience to meet your particular healthcare needs who is able to provide the requested healthcare service. For a utilization review appeal of an out-of-network referral or authorization denial, you or your designee must submit a written statement from your attending physician, who must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition:
   - That the participating provider recommended by us does not have the appropriate training and experience to meet your particular healthcare needs for the healthcare service; and
   - Recommending a nonparticipating provider with the appropriate training and experience to meet your particular healthcare needs who is able to provide the requested healthcare service.

I. Standard appeal.

1. **Preauthorization appeal.** If your appeal relates to a preauthorization request, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the

determination will be provided to you (or your designee), and where appropriate, your provider, within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

2. **Retrospective appeal.** If your appeal relates to a retrospective claim, we will decide the appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the appeal or 60 days of receipt of the appeal. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

3. **Expedited appeal.** An appeal of a review of continued or extended healthcare services, additional services rendered in the course of continued treatment, home healthcare services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one 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 business days of receipt of the information necessary to conduct the appeal. Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the appeal request.

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

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

J. Full and fair review of an appeal

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

K. Appeal assistance

If you need Assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 888-614-5400
Email: cha@cssny.org
Website: communityhealthadvocates.org

SECTION XXI – EXTERNAL APPEAL

A. Your right to an external appeal
In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service is not medically necessary (including appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, or is an emergency service or a surprise bill (including whether the correct cost-sharing was applied you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal, you must meet the following two requirements:

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

B. Your right to appeal a determination that a service is not medically necessary
If we have denied coverage on the basis that the service is not medically necessary, you may appeal to an external appeal agent if you meet the requirements for an external appeal in paragraph "A" above.

C. Your right to appeal a determination that a service is experimental or investigational
If we have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external appeal in paragraph "A" above and your attending physician must certify that your condition or disease is one for which:

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

In addition, your attending physician must have recommended one of the following:

1. A service, procedure, or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (Only certain documents will be considered in support of this recommendation. Your attending physician should contact the State for current information as to what documents will be considered or acceptable.)

2. A clinical trial for which you are eligible (only certain clinical trials can be considered)
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

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

D. Your right to appeal a determination that a service is out-of-network
If we have denied coverage of an out-of-network treatment because it is not materially different from the health service available in-network, you may appeal to an external appeal agent if you meet the two requirements for an external appeal in paragraph "A" above, and you have requested preauthorization for the out-of-network treatment.

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

The physician must be a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

E. Your right to appeal an out-of-network preauthorization denial to a nonparticipating provider
If we have denied coverage of a request for an authorization to a nonparticipating provider because we determine we have a participating provider with the appropriate training and experience to meet your particular healthcare needs who is able to provide the requested healthcare service, you may appeal to an external appeal agent if you meet the two requirements for an external appeal in paragraph "A" above.

In addition, your attending physician must: certify that the participating provider recommended by us does not have the appropriate training and experience to meet your particular healthcare needs; and recommend a nonparticipating provider with the appropriate training and experience to meet your particular healthcare needs who is able to provide the requested healthcare service.

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

F. Your right to appeal a formulary exception denial
If we have denied your request for coverage of a non-formulary prescription drug through our formulary exception process, you, your designee, or the prescribing healthcare professional may appeal the formulary exception denial to an external appeal agent. See the **Prescription drug coverage** section of this contract for more information on the formulary exception process.

G. The external appeal process
You as the member have four months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. Your provider has 60 days from the receipt of the final adverse determination or from receipt of the waiver of the internal appeal to file an external appeal.

If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal.

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

If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or us. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

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

If your internal formulary exception request received a standard review through our formulary exception process, the external appeal agent must make a decision on your external appeal and notify you or your designee and the prescribing healthcare professional by telephone within 72 hours of receipt of your completed application. The external appeal agent will notify you or your designee and the prescribing healthcare professional in writing within two business days of making a determination. If the external appeal agent overturns our denial, we will cover the prescription drug while you are taking the prescription drug, including any refills.

If your internal formulary exception request received an expedited review through our formulary exception process, the external appeal agent must make a decision on your external appeal and notify you or your designee and the prescribing healthcare professional by telephone within 24 hours of receipt of your completed application. The external appeal agent will notify you or your designee and the prescribing healthcare professional in writing within two business days of making a determination. If the external appeal agent overturns our denial, we will cover the prescription drug while you suffer from the health condition that may seriously jeopardize your health, life, or ability to regain maximum function or for the duration of your current course of treatment using the non-formulary prescription drug.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of this contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-healthcare services, the costs of managing the research, or costs that would not be covered under this contract for non-investigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

H. Your responsibilities

It is your responsibility to start the external appeal process.

You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXII – TERMINATION OF COVERAGE

A. Automatic termination of this contract

1. Upon your death
2. When you turn 65, your coverage will end at the end of the month in which you turn 65 or become Medicare-eligible
3. When you become Medicaid-eligible or enroll in the Medicaid program, your coverage will end at the end of the month in which you are determined to be Medicaid-eligible
4. When your income exceeds 200 percent of the Federal Poverty Level, your coverage will end at the end of the month in which your income has changed
5. When you have had a change in immigration status that makes you eligible for other coverage, including Medicaid, and your coverage will end at the end of the month before you are determined to be Medicaid-eligible
6. When you have enrolled in a different program through the NY State of Health Marketplace
7. When you have enrolled in affordable Employer Sponsored Health Insurance

B. Termination by you

You may terminate this contract at any time by giving the NYSOH at least 14 days' prior written notice.

C. Termination by us

We may terminate this contract with 30 days' written notice as follows:

1. Nonpayment of premiums

Premiums are to be paid by you to us on each premium due date. While each premium is due by the due date, there is a grace period for each premium payment. If the premium payment is not received by the end of the grace period, coverage will terminate as follows:

- If you fail to pay the required premium within a 30-day grace period, this contract will terminate on the last day of the 30-day grace period. You will not be responsible for paying any claims submitted during the grace period if this contract terminates.

2. Fraud or intentional misrepresentation of material fact

If you have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on your enrollment application, or in order to obtain coverage for a service, this contract will terminate immediately upon a written notice to you from the NYSOH. However, if you make an intentional misrepresentation of material fact in writing on your enrollment application, we will rescind this contract if the facts misrepresented would have led us to refuse to issue this contract and the application is attached to this contract. Rescission means that the termination of your coverage will have a retroactive effect of up to one year; the issuance of this contract.

3. If you no longer live or reside in our service area.

4. The date the contract is terminated because we stop offering the class of contracts to which this contract belongs, without regard to claims experience or health-related status of this contract. We will provide you with at least 90 days' prior written notice.

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

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

SECTION XXIII – TEMPORARY SUSPENSION RIGHTS FOR ARMED FORCES MEMBERS

If you, the subscriber, are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

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

You must make a written request to us to have your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty, your coverage may be resumed as long as you:

1. Make written application to us
2. Remit the premium within 60 days of the termination of active duty

The right of resumption extends to coverage for your dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXIV – GENERAL PROVISIONS

1. Agreements between us and participating providers
Any agreement between us and participating providers may only be terminated by us or the providers. This contract does not require any provider to accept a subscriber as a patient. We do not guarantee a subscriber's admission to any participating provider or any health benefits program.

2. Assignment
You cannot assign any benefits under this contract to any person, corporation, or other organization unless it is an assignment to your provider for a surprise bill. Any assignment by you other than for monies due for a surprise bill or an assignment of monies due to a hospital for emergency services, including inpatient services following emergency department care, will be void and unenforceable.

Assignment means the transfer to another person, corporation, or other organization of your right to the services provided under this contract or your right to collect money from us for those services.

3. Changes in this contract
We may unilaterally change this contract upon renewal, if we give you 45 days' prior written notice.

4. Choice of law
This contract shall be governed by the laws of the State of New York.

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

6. Conformity with law
Any term of this contract which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to comply with the minimum requirements of such law.

7. Continuation of benefit limitations
Some of the benefits in this contract may be limited to a specific number of visits. You will not be entitled to any additional benefits if your coverage status should change during the year. For example, your coverage terminates and you enroll in the product later in the year.

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

9. Fraud and abusive billing
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from nonparticipating providers could be balance billed additional charges by the nonparticipating provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing information and audit
You will promptly furnish us with all information and records that we may require from time to time to perform our obligations under this contract. You must provide us with information over the telephone for reasons such as the following: to allow us to determine the level of care you need; so that we may certify care authorized by your physician; or to make decisions regarding the medical necessity of your care.

11. Identification cards
Identification (ID) cards are issued by us for identification purposes only. Possession of any ID card confers no right to services or benefits under this contract. 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 in an application for coverage under this contract shall avoid the contract or be used in any legal proceeding unless the application or an exact copy is attached to this contract. After two years from the date of issue of this contract, no misstatements, except for fraudulent misstatements made by you in the application for coverage, shall be used to void the contract or deny a claim.

13. Independent contractors
Participating providers are independent contractors. They are not our agents or employees. We and our employees are not the agent or employee of any participating provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you while receiving care from any participating provider or in any participating provider's facility.

14. Input in developing our policies
We value your ideas. You can help us develop policies that best serve our members.
If you have ideas, tell us about them. You may participate in the development of our policies by calling Member Services at 800-300-8181 (TTY 711).

15. Material accessibility
We will give you ID cards, contracts, riders, and other necessary materials.

16. More information about Empire
You can request additional information about your coverage under this contract. Upon your request, we will provide the following information:

- A list of the names, business addresses, and official positions of our board of directors, officers, and members; and our most recent annual certified financial statement, which includes a balance sheet and a summary of the receipts and disbursements
- The information that we provide the State regarding our consumer complaints
- A copy of our procedures for maintaining confidentiality of subscriber information
- A copy of our drug formulary. You may also inquire if a specific drug is covered under this contract.
- A written description of our quality assurance program
- A copy of our medical policy regarding an experimental or investigational drug, medical device, or treatment in clinical trials
- Provider affiliations with participating hospitals
- A copy of our clinical review criteria (e.g., medical necessity criteria), and where appropriate, other clinical information we may consider regarding a specific disease, course of treatment, or utilization review guidelines, including clinical review criteria relating to a step therapy protocol override determination
- Written application procedures and minimum qualification requirements for providers
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the contract

17. Notice
Any notice that we give you under this contract will be mailed to your address as it appears in our records. 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:

Empire BlueCross BlueShield HealthPlus
P.O. Box 61010
Virginia Beach, VA 23466-1010

18. Premium payment
The first month's premium, if any, is due and payable when you apply for coverage. Coverage will begin on the effective date of the contract as defined herein. Subsequent premiums are due and payable on the first of each month thereafter. If a premium payment is made in error, we will issue you a refund of the amount overpaid.

19. Premium refund.
We will give any refund of premiums, if due, to you.

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

21. Renewal date
The renewal date for this contract is 12 months after the effective date of this contract. This contract will automatically renew each year on the renewal date, as long as you remain eligible under the contract and unless otherwise terminated by us as permitted by this contract. The contract does not automatically renew and an action is needed from the member at a minimum on an annual basis. The member should be referred to the Retention department for any renewal questions at 888-809-8009 (TTY 711).

22. Reinstatement after default
If you default in making any payment under this contract, the subsequent acceptance of payment by us or by one of our authorized agents or brokers shall reinstate the contract. The acceptance of a subsequent payment does support reinstatement, but with a possible gap in coverage.

23. Right to develop guidelines and administrative rules
We may develop or adopt standards that describe in more detail when we will or will not make payments under this contract. Examples of the use of the standards are to determine whether: hospital inpatient care was medically necessary; surgery was medically necessary to treat your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this contract. If you have a question about the standards that apply to a particular benefit, you may contact us and we will explain the standards or send you a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this contract.

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 healthcare 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. Our medical director and the doctors in our plan review new medical advances or changes to technology in:
- Behavioral health.
- Devices.
- Medical treatment.
- Prescription drugs.

They also look at scientific findings to see if these new medical advances and treatments:
- Are considered safe and effective by the government.
- Give equal or better outcomes than the treatment or therapy that exists now.

24. Right to offset
If we make a claim payment to you or on your behalf in error or you owe us any money, you must repay the amount you owe us. Except as otherwise required by law, if we owe you a payment for other claims received, we have the right to subtract any amount you owe us from any payment we owe you.

25. Service marks
Services provided by HealthPlus HP, LLC, a licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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

27. Significant change in circumstances
If we are unable to arrange for covered services as provided under this contract as the result of events outside of our control, we will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of participating providers' personnel, or similar causes. We will make reasonable attempts to arrange for covered services. We and our participating providers will not be liable for delay, or failure to provide or arrange for covered services if such failure or delay is caused by such an event.

28. Subrogation and reimbursement
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness, or other condition and we have provided benefits related to that injury, illness, or condition. As permitted by applicable state law, unless pre-empted by federal law, we may be subrogated to all rights of recovery against any such party (including your own insurance carrier) for the benefits we have provided to you under this contract. Subrogation means that we have the right, independently of you, to proceed directly against the other party to recover the benefits that we have provided.

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

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

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

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

31. Translation services
Translation services are available free of charge under this contract for non-English-speaking subscribers. Please contact us at 800-300-8181 (TTY 711) to access these services.

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

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

34. Who may change this contract
This contract may not be modified, amended, or changed, except in writing and signed by our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

35. Who receives payment under this contract
Payments under this contract for services provided by a participating provider will be made directly by us to the provider. If you receive services from a nonparticipating provider, we reserve the right to pay either you or the provider. If you assign benefits for a surprise bill to a nonparticipating provider, we will pay the nonparticipating provider directly. See the **How your coverage works** section of this contract for more information about surprise bills.

36. Workers' compensation not affected
The coverage provided under this contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

37. Your medical records and reports
In order to provide your coverage under this contract, it may be necessary for us to obtain your medical records and information from providers who treated you. Our actions to provide that coverage include processing your claims, reviewing grievances, appeals, or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this contract, except as prohibited by state or federal law, you automatically give us or our designee permission to obtain and use your medical records for those purposes and you authorize each and every provider who renders services to you to:

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

We agree to maintain your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, you automatically give us permission to share your information with the New York State Department of Health, and other authorized federal, state, and local agencies with authority over the Essential Plan, quality oversight organizations, and third parties with which we contract to assist us in administering this contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements. If you want to take away any permissions you gave to release this information, you may call us at 800-300-8181 (TTY 711).

38. Y**our rights and responsibilities**
As a member, you have rights and responsibilities when receiving healthcare. As your healthcare partner, we want to make sure your rights are respected while providing your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms you can reasonably understand.

When it is not advisable to give such information to you, the information shall be made available to an appropriate person acting on your behalf.

You have the right to receive information from your physician or other provider that you need in order to give your informed consent prior to the start of any procedure or treatment.

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

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

You have the right to access our participating providers.

You also have the right to:

- Receive information about Empire BlueCross BlueShield HealthPlus, our services, policies, procedures, and doctors.
- Be given privacy and treated with dignity and respect.
- Be told about your rights and responsibilities and make suggestions about them.
- Hear about all available treatment options, no matter what your benefits cover or how much they cost.
- Work with your doctor to improve your health.
- Be told if any changes are made to these items.

As a member, you should also take an active role in your care. We encourage you to:

- Understand your health problems as well as you can and work with your providers to make a treatment plan that you all agree on.
- Follow the treatment plan that you have agreed on with your doctors or providers.
- Give us, your doctors and other providers the information needed to help you receive the care you need and all the benefits you are eligible for under your contract. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform us if you have any changes to your name, address or dependents covered under your contract.
- Give your doctor the correct information about your health.
- Ask questions so you can understand your health conditions and/or treatment options.
- Talk with your doctor about treatment and follow the instructions for care.

For additional information regarding your rights and responsibilities, visit the FAQ on our website at empireblue.com/nyessentialplan. If you do not have internet access, you can call us at 800-300-8181 (TTY 711) to request a copy. If you need more information or would like to contact us, please go to our website at empireblue.com/nyessentialplan or call us at 800-300-8181 (TTY 711).

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN RECEIVE ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We receive information about you from state agencies for Medicaid, the Essential Plan, and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also receive it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't have it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can log in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals, and others provide you the care you need
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we'll pay for healthcare or services before you receive them

  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit **empireblue.com/ny** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from becoming sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

We must receive your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to receive your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:
- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from becoming sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you become sick or hurt at work

What are your rights?
- You can ask to look at your PHI and receive a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.

- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business, or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?
- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at 800-300-8181 (TTY 711).

What if you have a complaint?
We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Ste. 3312
New York, NY 10278
Phone: 800-368-1019
TDD: 800-537-7697
Fax: 212-264-3039

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **empireblue.com/ny**.

Race, ethnicity, and language
We receive race, ethnicity, and language information about you from the state Medicaid agency, the Essential Plan and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you receive the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:
- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

Your personal information
We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may receive PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

empireblue.com/ny
Services provided by HealthPlus HP, LLC, a licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Revised November 20, 2017

NOTICE OF NON-DISCRIMINATION

Empire BlueCross BlueShield HealthPlus complies with Federal civil rights laws. **Empire** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Empire provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Empire** at 800-300-8181. For TTY/TDD services, call 711.

If you believe that **Empire** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Empire** by:

Mail:	<9 Pine St., 14th Floor, New York, NY 10005
Phone:	800-300-8181 (TTY 711)
Fax:	866-495-8716
In person:	9 Pine St., 14th Floor, New York, NY 10005>

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail:	U.S. Department of Health and Human Services 200 Independence Ave. SW, Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://hhs.gov/ocr/office/file/index.html
Phone:	800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 800-300-8181 (TTY 711).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-300-8181 (TTY 711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-300-8181 (TTY 711).	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-300-8181 (رقم هاتف الصم والبكم) (TTY 711)	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 800-300-8181 (TTY 711) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-300-8181 (телетайп: TTY 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-300-8181 (TTY 711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-300-8181 (TTY 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-300-8181 (TTY 711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY 711) 800-300-8181.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-300-8181 (TTY 711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-300-8181 (TTY 711).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ঃ- 800-300-8181 (TTY 711).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-300-8181 (TTY 711).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800-300-8181 (TTY 711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 800-300-8181 (TTY 711).	Urdu

SECTION XXV – EMPIRE BLUECROSS BLUESHIELD HEALTHPLUS SCHEDULE OF BENEFITS

*See **Benefit description** in contract for more details.

Nonparticipating provider services are not covered for any services other than those related to emergency care and you pay the full cost for services performed by a nonparticipating provider except in cases related to emergency care.

Cost sharing	Essential Plan 4
Deductible • Individual **Out-of-pocket limit** • Individual Deductibles, coinsurance, and copays that make up your out-of-pocket limit accumulate on a plan year basis.	$0 $0
Office visits	
Primary care office visits (or home visits)	$0
Specialist office visits (or home visits)	$0
Preventive care	
• Adult annual physical examinations* • Adult immunizations* • Routine gynecological services/well-woman exams* • Mammograms, screening, and diagnostic imaging for the detection of breast cancer* • Sterilization procedures for women* • Vasectomy	Covered in full Covered in full Covered in full Covered in full Covered in full See **Surgical services** section Use cost sharing for appropriate service (surgical services, anesthesia services, ambulatory surgical center facility fee; outpatient hospital surgery facility charge) See **Surgical services** section

• Bone density testing* • Screening for prostate cancer • All other preventive services required by USPSTF and HRSA *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full Covered in full Use cost sharing for appropriate service (primary care office visit, specialist office visit, diagnostic radiology services, lab procedures, and diagnostic testing)
Emergency care	
Pre-hospital emergency medical services (ambulance services)	$0
Nonemergency ambulance services	$0 **See contract on how to use this service**
Emergency department Copay waived if admitted to hospital	$0
Urgent care center	$0 **Preauthorization required for out-of-network urgent care**
Professional services and outpatient care	
Advanced imaging services • Performed in a freestanding radiology facility or office setting • Performed in a specialist office • Performed as outpatient hospital services	 $0 $0 $0 **Preauthorization required**
Allergy testing and treatment • Performed in a PCP office • Performed in a specialist office	 $0 $0
Ambulatory surgical center facility	$0
Anesthesia services (all settings)	Covered in full
Autologous blood banking	Covered in full
Cardiac and pulmonary rehabilitation • Performed in a specialist office	 $0

• Performed as outpatient hospital services • Performed as inpatient hospital services	$0 Included as part of inpatient hospital service cost sharing
Chemotherapy and immunotherapy Administration • Performed in a PCP office • Performed in a specialist office • Performed as outpatient hospital services • Performed at home • Chemotherapy and immunotherapy medications	 $0 $0 $0 $0 $0
Chiropractic services	$0 **Preauthorization required after the first five visits**
Clinical trials	Use cost sharing for appropriate service **Preauthorization required**
Diagnostic testing • Performed in a PCP office • Performed in a specialist office • Performed as outpatient hospital services	 $0 $0 $0
Dialysis • Performed in a PCP office • Performed in a freestanding center or specialist office setting • Performed as outpatient hospital services • Performed at home	 $0 $0 $0 $0
Habilitation services (physical therapy, speech therapy, or occupational therapy)	$0 **Preauthorization required**

60 visits per condition, per plan year combined therapies	
Home healthcare 40 visits per plan year	$0 **Preauthorization required**
Infertility services	Use cost sharing for appropriate service (office visit, diagnostic radiology services, surgery, lab, and diagnostic procedures)
Infusion therapy Administration • Performed in a PCP office • Performed in specialist office • Performed as outpatient hospital services • Home infusion therapy • Infusion therapy medication (Home infusion counts toward home healthcare visit limits)	 $0 $0 $0 $0 $0
Inpatient medical visits	$0 per admission **Admission preauthorization required**
Interruption of pregnancy • Medically necessary abortions (unlimited) • Elective abortions (one procedure per plan year)	 Covered in full $0
Lab procedures • Performed in a PCP office • Performed in a specialist office • Performed in a freestanding lab facility or specialist office • Performed as outpatient hospital services	 $0 $0 $0 $0 **Preauthorization required**
Maternity and newborn care	

• Prenatal care • Inpatient hospital services and birthing center (one home care visit is covered at no cost sharing if mother is discharged from hospital early) • Physician and midwife services for delivery • Breastfeeding support, counseling, and supplies, including breast pumps (covered for duration of breastfeeding) • Postnatal care	$0 $0 $0 $0 Included in physician and midwife services for delivery cost sharing **Preauthorization required for inpatient services breast pump**
Outpatient hospital surgery facility charge	$0
Preadmission testing	$0
Prescription drugs administered in office Administration • Performed in a PCP office • Performed in a specialist office • Performed as outpatient hospital services • Prescription drug cost sharing	 $0 $0 $0 $0
Diagnostic radiology services • Performed in a PCP office • Performed in a specialist office • Performed in a freestanding radiology facility • Performed as outpatient hospital services	 $0 $0 $0 $0 **Preauthorization required**
Therapeutic radiology services	

• Performed in a specialist office • Performed in a freestanding radiology facility • Performed as outpatient hospital services	$0 $0 $0 **Preauthorization required**
Rehabilitation services (physical therapy, occupational therapy, or speech therapy) 60 visits per condition, per plan year combined therapies Speech and physical therapy are only covered following a hospital stay or surgery • Performed in a PCP office • Performed in a specialist office • Performed in an outpatient facility	$0 $0 $0 **Preauthorization required**
Retail health clinic care	$0
Second opinions on the diagnosis of cancer, surgery, and other	$0 **Preauthorization required**
Surgical services (including oral surgery; reconstructive breast surgery, other reconstructive and corrective surgery, transplants, and interruption of pregnancy) **All transplants must be performed at designated Center of Excellence facilities** • Inpatient hospital surgery • Outpatient hospital surgery • Surgery performed at an ambulatory surgical center • Office surgery	$0 $0 $0 $0 **Preauthorization required**
Telemedicine program	$0
Additional services, equipment and devices	
ABA treatment for autism spectrum disorder	$0

	Preauthorization required
Assistive communication devices for autism spectrum disorder	$0 **Preauthorization required**
Diabetic equipment, supplies, and self-management education • Diabetic equipment, supplies, and insulin (30-day; up to a 90-day supply) • Diabetic education	 $0 (per 30-day supply) $0
Durable medical equipment and braces	$0 **Preauthorization required**
External hearing aids **(Single purchase one every three years)**	$0 **Preauthorization required**
Cochlear implants **(One per ear per time covered)**	$0 **Preauthorization required**
Hospice care • Inpatient • Outpatient 210 days per plan year Five visits for family bereavement counseling	 $0 $0 **Preauthorization required**
Medical supplies	$0
Prosthetic devices • External One prosthetic device, per limb, per lifetime, with coverage for repairs and replacements • Internal	 $0 Included as part of inpatient hospital cost sharing **Preauthorization required**
Inpatient services and facilities	

Inpatient hospital for a continuous confinement (including an inpatient stay for mastectomy care, cardiac and pulmonary rehabilitation, and end of life care)	$0 **Preauthorization required. However, preauthorization is not required for emergency admissions.**
Observation stay Copay waived if direct transfer from outpatient surgery setting to observation	$0
Skilled nursing facility (including cardiac and pulmonary rehabilitation) 200 days per plan year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	$0 **Preauthorization required**
Inpatient habilitation services (physical, speech, and occupational therapy)	$0 **Preauthorization required**
Inpatient rehabilitation services (physical, speech, and occupational therapy)	$0 **Preauthorization required**
Mental health and substance use disorder services	
Inpatient mental healthcare including residential treatment (for a continuous confinement when in a hospital)	$0 **Preauthorization required. However, preauthorization is not required for emergency admissions.**
Outpatient mental healthcare (including partial hospitalization and intensive outpatient program services) • Office visits • All other outpatient services	 $0 $0 **Preauthorization required**
ABA Treatment for Autism Spectrum Disorder [[Preauthorization; Referral] required]	

Assistive Communication Devices for Autism Spectrum Disorder [[Preauthorization; Referral] required]	
Inpatient substance use services for a continuous confinement when in a hospital (including residential treatment)	$0 **Preauthorization required. However, preauthorization is not required for emergency admissions or for participating OASAS-certified facilities.**
Outpatient substance use services (including partial hospitalization, intensive outpatient program services, and medication assisted treatment)	$0 **Preauthorization required**
Prescription drugs *Certain prescription drugs are not subject to cost sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.	
Retail pharmacy	
30-day supply Tier 1 Tier 2 Tier 3 Preauthorization is not required for a covered prescription drug used to treat a substance use disorder including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $0 $0 $0
Mail-order pharmacy	
Up to a 30-day supply Tier 1 Tier 2	 $0 $0

Tier 3	$0
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $0 $0 $0
Enteral formulas Tier 1 Tier 2 Tier 3	See benefit for description
Nonprescription drugs	$0
Wellness benefits	
Gym reimbursement	Up to $200 per six-month period
Dental and vision care	
Dental care • Preventive dental care • Routine dental care • Major dental (oral surgery, endodontics, periodontics, and prosthodontics) One dental exam and cleaning per six-month period. Full mouth X-rays or panoramic X-rays at 36-month intervals and bitewing X-rays at six to 12-month intervals	 $0 $0 $0 **Orthodontics and major dental require preauthorization**
Vision care • Exams • Lenses and frames • Contact lenses	 $0 $0 $0 **One exam per 24-month period, unless otherwise medically necessary** **One prescribed lenses and frames per 24-month period,**

	unless otherwise medically necessary **Contact lenses require preauthorization**

All in-network preauthorization requests are the responsibility of your participating provider. You will not be penalized for a participating provider's failure to obtain a required preauthorization. However, if services are not covered under contract, you will be responsible for the full cost of the services.

800-300-8181 (TTY 711)

empireblue.com/nyessentialplan