

HMO

**THIS IS YOUR  
EMPIRE HEALTHCHOICE HMO, INC.  
CERTIFICATE OF COVERAGE  
Issued by  
EMPIRE HEALTHCHOICE HMO, INC.**

This is your Certificate of health maintenance organization coverage provided by Empire HealthChoice HMO, Inc.

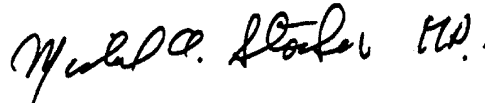
**IMPORTANT NOTICE**

**In order to receive benefits under this Certificate you must contact your Primary Care Physician (“PCP”) in advance, except in an emergency as described in Section Seven of this Certificate. Empire HealthChoice HMO, Inc. will only pay for medically necessary care provided by Participating Providers as authorized by your PCP, except in an emergency or unless specifically stated otherwise in this Certificate.**

**EMPIRE HEALTHCHOICE HMO, INC.  
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SETH TRUWIT  
SECRETARY



MICHAEL A. STOCKER, M.D.  
PRESIDENT AND CHIEF EXECUTIVE OFFICER

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## SECTION ONE - INTRODUCTION; DEFINITIONS; MEDICAL MANAGEMENT PROGRAM

- 1. Health Care Through The HMO Concept.** This Certificate provides coverage through a Health Maintenance Organization (HMO). In an HMO all care must be medically necessary and must be provided, or authorized in writing in advance, by your PCP. Except for emergencies, payment for care you receive without the prior written approval of your PCP will be denied, even if it is medically necessary. In addition, benefits will only be provided for care that is rendered by Participating Providers, except in the case of an emergency or when, in our sole judgment, the care you require is not available from a Participating Provider and we preauthorize services of the non-participating provider.

In some cases, your PCP may provide or approve services that are not covered by Empire because they are specifically excluded in this Certificate. In spite of your PCP's authorization, Empire will not pay for these services.

Since care must be provided or authorized by your PCP, coverage is not available, and we will not pay for, any services unless you have a PCP. Each person who has this HMO coverage should select a PCP from the list of Participating HMO Primary Care Physicians. If you do not select a PCP, we will assign one. Throughout this Certificate, the Participating HMO Primary Care Physician you have selected will be referred to as "your PCP."

- 2. Words We Use.** Throughout this Certificate, Empire will be referred to as "we," "us" or "our." The word "you," "your," or "yours" refers to you, the one person to whom this Certificate is issued. If family coverage was selected, then in most cases the word "you" also includes any members of your family who are covered under this Certificate.
- 3. Group Subscriber.** You are covered under this Certificate as a group subscriber because an organization, such as an employer, union or association arranged for your coverage. To be a group subscriber, you must meet our group eligibility rules. Your group then acts on your behalf, sending us the premium for this coverage. The group has a contract with us to provide HMO coverage. Under that contract we will provide the benefits described in this Certificate. This Certificate is not a contract between you and us, but you should keep it with your important papers and refer to it if you have questions about your coverage.

- 4. Definitions.** The following definitions apply to your HMO coverage:

**Certificate** means this certificate of coverage.

**Copayment** means the amount of payment you must make for some services. It includes the visit fees you must pay for visits to physicians and, for example, the payment you must make for care in a hospital emergency room when you are not admitted as an inpatient within one day for the same condition.

**Custodial Care** means care which we determine is designed chiefly to assist a person to meet her or his activities of daily living as defined by Medicare Guidelines. Such care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled nursing care. Examples of custodial care include but are not limited to:

- A. Service which constitutes personal care, such as walking and getting in and out of bed, aid in bathing, dressing, feeding, and using the toilet;
- B. Preparation of special diets; or
- C. Supervision of medication which usually can be self-administered.

**Emergency** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, 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 in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; or serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person.

**Facilities** means a hospital, ambulatory surgery facility, birthing center, dialysis center, rehabilitation facility, skilled nursing facility or other provider certified under Article 28 of the N.Y. Public Health Law; a hospice; or an institutional provider of mental health substance abuse treatment operating under Article 31 of the N.Y. Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services.

**HMO** means Empire HealthChoice HMO, Inc.

**Medical Management Program** means the managed care program described below in this Section. Compliance with the Medical Management Program is required in order to receive benefits under this Certificate.

**Medically Necessary** means care which, according to our criteria, and in our judgment, is:

- Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
- In accordance with standards of good medical practice;
- Not solely for your convenience, or that of your physician or other provider;
- Not primarily custodial; and
- The most appropriate supply or level of service which can safely be provided to you.

**Mental and Behavioral Health Care Manager** means the managed care program designed to provide advance, written authorization for mental health care benefits. This includes benefits for alcohol and substance abuse.

**Participating Physician** means a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has an agreement to provide covered services to HMO members.

**Participating Provider** means any professional provider, or a hospital, skilled nursing or other Facility, home health agency, laboratory, or any other person or entity which has an agreement to provide covered services to HMO members and participates in the network chosen by your group. We will not pay for health services from a non-participating provider except in an emergency or when, in our sole judgment, the care you require is not available from a Participating Provider and we preauthorize services of the non-participating provider.

**Primary Care Physician (“PCP”)** means the Participating Physician you select when you enroll in the HMO, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.

**Referral Care** means covered medical care which is provided by a participating practitioner other than your PCP and which is:

- Authorized, in advance, by your PCP, in writing or by such other method as we may designate from time-to-time; and
- Limited in scope, duration or number of visits to that authorized by your PCP.

**Service Area** means the 28 counties in eastern New York including New York City and from there north through Clinton County, and east through Suffolk County. Specifically, those counties are: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

**Skilled Care** means a service which we determine is furnished by or under the direct supervision of licensed medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result as defined by Medicare Guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical or paramedical personnel. However, it is a service which cannot be safely and adequately self-administered or performed by the average non- medical person without the supervision of such personnel.

5. **Medical Management Program.** The Medical Management Program (MMP) is a program which must be complied with in order to receive the benefits available under this Certificate. MMP works with you and/or your Participating Provider to ensure that you receive medically appropriate health services at an appropriate level of medical care.

The following services require authorization prior to your receiving the services:

A. You or your PCP must call the Mental and Behavioral Health Care Manager for authorization prior to receiving the following services:

- Inpatient or outpatient mental health care;
- Inpatient alcohol and substance abuse detoxification;
- Outpatient alcohol and substance abuse care.

The Mental and Behavioral Health Care Manager can be contacted at the telephone number listed on your identification card.

B. The following services must be preauthorized by MMP:

- All inpatient admissions;
- Air ambulance;
- Ambulatory surgery;
- Cardiac rehabilitation;
- Durable medical equipment and prosthetics;
- Home care and home infusion therapy;
- Hospice care;
- MRIs;
- Occupational and physical therapy;
- Skilled nursing facility care;
- Speech therapy;
- Vision therapy.

C. MMP must be called:

- At least two weeks prior to the planned admission or surgery when your Participating Physician recommends inpatient hospitalization. If that is not possible, then during regular business hours any time prior to admission.
- Within 24 hours after you are admitted to a hospital because of an Emergency or as soon as reasonably possible.
- Within the first three months of a pregnancy and again within 24 hours after the actual delivery date or as soon as reasonably possible.
- In all other cases, prior to receiving the services.

The MMP staff must be contacted by your attending Participating Physician, Home Health Agency, Durable Medical Equipment or Prosthetics Vendor, as appropriate.

The MMP staff will discuss the planned level of care with you and your attending Participating Physician to determine a level of care which is appropriate to the planned health services and advise you, your attending physician, and the hospital in writing and by telephone of the approved level of care within three (3) business days after the staff receives all the necessary medical information from the attending physician.

The preauthorization of benefits by the MMP or the Mental and Behavioral Health Care Manager does not guarantee payment of benefits. All benefits must be Medically Necessary as determined by us. The payment of benefits is limited by the terms, conditions and limitations of this Certificate.

- D. Please refer to your HMO Member Handbook for a description of how you or your provider can appeal a decision by MMP.

## SECTION TWO - WHO IS COVERED

1. **Who is Covered.** You, the person to whom this Certificate is issued, are covered under this Certificate and, if you selected family coverage, the following members of your family are also covered:
  - A. Your wife or husband, unless you are divorced or your marriage has been annulled.
  - B. Your unmarried children who are under the age limit shown on the attached Schedule of Benefits. Coverage of each child lasts until December 31 of the calendar year in which the child becomes that age, or the date of marriage, whichever occurs first.
  - C. Your unmarried children who are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which coverage would otherwise terminate according to this Section. The child's disability must be certified by a physician. In addition to this certification, we have the right to check whether a child is and continues to qualify as an incapacitated child.
  - D. Your unmarried children under the age shown on the attached Schedule of Benefits, enrolled as full-time students at an accredited institution of learning. The students' principal residence, when not away at school, must be the same as their parents'. Coverage of each child lasts until December 31 of the calendar year in which the child no longer meets all of these conditions, or the date of marriage, whichever occurs first.
2. **Other Covered Children.** If you have family coverage the following other children, in addition to the natural children of you and your spouse, are also covered if the child meets the above criteria for covered children:
  - A child for whom you are the legal guardian and who is chiefly dependent upon you for support.
  - A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final. Foster children are not included.
3. **Newborn Child.** If you have family coverage, your newborn child will be covered from the date of birth. However, if a child of yours who is covered gives birth, that newborn grandchild will not be covered. If the grandparent adopts the newborn, coverage will be effective as described in Paragraph 4 below. If the grandparent becomes the legal

guardian of the child, the child will be covered from the effective date of the legal guardianship.

If you have individual or two-person coverage, any newborn child will be covered for thirty (30) days from the date of birth. If you have individual or two-person coverage at the time your child is born, you must switch to two-person or family coverage to receive further benefits and to obtain coverage for your newborn from the moment of birth. You must notify us of your desire to switch to two-person or family coverage and we must receive the applicable premium for the new coverage within 60 days of the birth. If you decide to switch to two-person or family coverage but fail to notify us or we do not receive the applicable premium within 60 days of the birth, you must wait until the group's open enrollment period; in that case, the coverage will not become effective until the first day of the month following the date the request is received and the applicable premium is paid.

**4. Coverage of Adopted Newborns.**

A. **When We Will Cover Adopted Newborns from the Moment of Birth.** If you have family coverage, or switch to two-person or family coverage in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

- You (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth; and
- You file a petition pursuant to Section 115-c of the New York State Domestic Relations Law within 30 days of the infant's birth.

B. **When We Will Not Cover Adopted Newborns From the Moment of Birth.** Notwithstanding the provisions of Paragraph A. above, we will not cover adopted newborns from the moment of birth if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we pay benefits to cover an adopted newborn and the notice of the adoption is revoked, or one of the natural parents revokes consent, we shall be entitled to recover any sums paid by us for care of the adopted newborn.

**5. Persons Not Covered.** If you live outside our Service Area you are not eligible for coverage under this Certificate unless you work in the Service Area and receive all covered health care there.

**6. When Coverage Begins.** Coverage under this Certificate will begin as follows:

- A. If you elect coverage before becoming eligible for coverage, coverage begins on the date you become eligible, or on the date on which we receive and accept from you a completed application, whichever is later.
- B. If you do not elect coverage upon becoming eligible, you must wait until the group's open enrollment period. Coverage then begins on the date on which we receive and accept from you a completed application.

- C. If you marry while covered, and we receive notice of such marriage within thirty (30) days thereafter, coverage for the spouse starts on the date of such marriage; otherwise you must wait until the group's open enrollment period; and in that case the spouse's coverage begins on the date on which we receive and accept from you a completed application.

**7. When You Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage.** If you reject initial enrollment under this Certificate, you may enroll for coverage if all of the following conditions are met:

- A. You were covered under another plan or contract when coverage was initially offered.
- B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you lost eligibility for one or more of the following reasons:
- termination of employment;
  - termination of the other plan or contract;
  - death of the spouse;
  - legal separation, divorce or annulment;
  - reduction in the number of hours worked; or
  - the employer or other group ceased its contribution toward the premium for the other plan or contract.
- C. You apply for coverage under this Certificate within 30 days after termination for one of the reasons set forth in Paragraph B. above.

**SECTION THREE - HOSPITAL CARE**

**1. Inpatient Care in a Hospital.** We will pay for the following services if they are customarily furnished by a hospital when you are a registered bed patient in a hospital:

- bed and board, including special diet and nutritional therapy
- general, special, and critical care nursing service, but not private duty nursing services
- facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care
- oxygen and other inhalation therapeutic services and supplies
- drugs and medications which are listed and approved for such use in the most recent Physician's Desk Reference, American Medical Association Drug Evaluations, American Hospital Formulary Drug Service Information, the United States Pharmacopeia Drug Information or other similar authoritative source
- sera, biological, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies
- blood, blood products, and blood derivatives and services and equipment related to their administration
- facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including, but not limited to,

laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations

- social, psychological and pastoral services
- facilities, services, supplies and equipment related to radiation and nuclear therapy
- facilities, services, supplies and equipment related to Emergency medical care
- any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital except to the extent that they are excluded by this Certificate
- chemotherapy
- radiation therapy.

We will only pay for these services if all the following conditions are met:

- A. Except in an Emergency, as defined in Section One above, the hospital is a “participating hospital.” A participating hospital is a hospital which has an agreement with us to participate as an HMO network hospital.
- B. Except in an Emergency, your admission is authorized in advance by your PCP following certification by MMP.
- C. While in the hospital you remain under the care of your PCP or another physician designated by your PCP.
- D. The service is given to you by an employee of the hospital, the hospital regularly bills for the service and the hospital retains the money collected for the service.

You do not have to meet all of the conditions described above for an admission to a hospital in an Emergency. See Section Seven.

**Maternity Benefits.** Inpatient hospital benefits include coverage for a mother and for her newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section, and for at least ninety-six (96) hours following a cesarean section.

If the mother decides to be discharged earlier than forty-eight (48) hours after childbirth for any delivery other than a cesarean section or ninety-six (96) hours following a cesarean section she shall be entitled, upon request made within that time period, to one home care visit. The visit shall be delivered within twenty-four (24) hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits described in Section Four. The home care visit shall not be subject to any copayment.

**Inpatient Mastectomy Stays.** Our coverage of inpatient hospital care includes coverage of any inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of the stay will be determined by you and your doctor.

**Copayment for Inpatient Hospital Care.** You must pay the copayment amount shown on the attached Schedule of Benefits when you are: admitted as an inpatient to a hospital as described in Paragraph 1 above.

The copayment applies to: psychiatric care; treatment of alcoholism and substance abuse; and inpatient admissions for physical therapy, physical medicine or rehabilitation. You do not have to pay the copayment for inpatient skilled nursing facility care described in Paragraph 5.C. below. You do not have to pay the copayment more than once in a single inpatient confinement. A single confinement includes a readmission within 90 days.

If you selected family coverage, after the total of copayments made by you and your family reaches the amount shown on the Schedule of Benefits, no one in your family will have to make any copayments for the remainder of that year.

2. **Outpatient Care in a Hospital.** Subject to the limitations described below, we will also pay for the same services provided to you in the outpatient department of a Participating Hospital as we would pay for if you were an inpatient. As in the case of inpatient care, your visit to the outpatient department must be authorized in advance by your PCP. Ambulatory surgery must also be pre-certified by us. Outpatient treatment of mental and nervous conditions is subject to the limitations set forth in Section Six below.

**Ambulatory Surgery.** We will pay for the participating Facility charges for covered surgery or procedures your physician recommends be performed in an ambulatory surgery setting.

Ambulatory surgery is defined as surgery consisting of surgical or invasive diagnostic procedures performed on patients who have not been admitted to hospitals as inpatients. Such procedures require the utilization of a surgical operating room and postoperative recovery room, may require the administration of local or general anesthesia, and must be limited to patients for whom admission as hospital inpatients is not otherwise Medically Necessary and appropriate. Ambulatory surgery procedures are limited to those procedures which could appropriately justify admission to a hospital for inpatient services in the absence of an ambulatory surgery program.

**Outpatient Surgery.** We will also pay for the participating Facility charges for surgery which includes closed reduction of fractures, dislocations of bones and endoscopies requiring the use of the surgical facilities. It does not include minor surgical procedures which do not require use of the surgical Facilities, and are normally provided in a doctor's office, such as the removal of cysts, warts, splinters or sutures. It does not include inoculation, vaccination, collection of blood, drug administration or injection.

**Therapy Services.** We will only pay for up to 30 visits per member per year for physical therapy and 30 visits per member per year for occupational and/or speech and/or vision therapy under the following conditions:

- The therapy must be skilled therapy. Skilled therapy is therapy which must be furnished by skilled licensed medical personnel in order to assure your safety and achieve the medically desired result.
- The therapy must be short term and intended to improve or restore your bodily functions within a reasonable and generally predictable period of time (usually not more than 60 days). We will not pay for maintenance therapy or therapy designed only to prevent further deterioration.

- We must certify the services in advance.

The 30/30 visit limits include, and are not in addition to, therapy services provided under Section Four.

**Mammography Screening.** We will pay for mammography screening for occult breast cancer as follows:

- Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer;
- A single baseline mammogram if you are age 35 through age 39 inclusive;
- A mammogram every 2 years, or more frequently upon the recommendation of a physician, if you are age 40 through 49 inclusive; and
- An annual mammogram if you are age 50 and older.

“Mammography Screening” shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

**Cervical Cancer Screening.** We will pay for cervical screening for females in the outpatient department of a participating hospital. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

**Blood.** We will pay for blood or human blood derivatives during an emergency or ambulatory surgery. We will also pay for this service outside of the hospital.

**Pre-Surgical Testing.** We will pay for pre-surgical testing when performed at the Participating Hospital where the surgery is scheduled to take place, if:

- reservations for a hospital bed and for an operating room at that hospital have been made prior to performance of the tests;
- your physician has ordered the tests; and
- proper diagnosis and treatment require the test; and
- the surgery takes place within 7 days of the tests.

If surgery is canceled because of these pre-surgical test findings or as a result of a Second Surgical Opinion we will still cover the cost of these tests, but they will not be covered when surgery is canceled for any other reason. See Section Four, Paragraph 3.I. for information concerning benefits for a Second Surgical Opinion.

**3. Hospital Services Not Covered.** We will not provide the following services:

- A. Private duty nurses.
- B. Private room. If you occupy a private room, you will have to pay the difference between the hospital’s charges for a private room and the hospital’s most common charge for semi-private accommodations.

C. Non-medical items, such as television rental and telephone charges.

D. Medications, supplies and equipment which you take home from the hospital or other facility.

**4. Number of Days of Hospital or Other Facility Care.** We will pay for care in a Participating Hospital under the conditions described above, on any day we determine that hospitalization was Medically Necessary for the care or treatment of your condition, illness or injury. We will not provide care after a date we determine that hospitalization was no longer Medically Necessary unless requested to by an external appeal agent. There are limitations on the number of days of care for psychiatric care, alcoholism or substance abuse, or nursing home care, which are described in “5” below.

**5. Limitations on Inpatient Care. Inpatient care will be limited in the following cases:**

A. **Psychiatric Care; Treatment of Alcoholism and Substance Abuse.** Inpatient admissions for psychiatric care and/or treatment of alcoholism or substance abuse are subject to the limitations set forth in Section Six below.

B. **Physical Therapy, Physical Medicine or Rehabilitation.** We will pay for 30 days in a calendar year for inpatient admissions to a Participating Hospital exclusively for physical therapy, physical medicine or rehabilitation or a combination of these services. We will only pay for services provided according to a plan of care in which you actively participate. The care you receive must be short term and reasonably expected to improve or restore your bodily functions within a reasonable and generally predictable period of time. We will not pay for care to maintain you at your present level or to prevent further deterioration.

C. **Care in a Skilled Nursing Facility.** We will provide care in a participating skilled nursing facility if we determine that hospitalization would otherwise be medically necessary for all or part of the care of your condition, illness or injury and MMP pre-certifies your admission.

Your Participating Physician must refer you to the skilled nursing facility prior to the time you entered the Facility and submit a written treatment plan to MMP which certifies: your condition, the projected length of stay in the Facility, the skilled services you are to receive in the Facility, and the intended benefits of this care in the Facility.

We must determine that you needed and actually received skilled nursing care or skilled rehabilitation service on a daily basis. A skilled service is one which must be furnished by skilled licensed personnel to assure your safety and achieve the medically desired result.

We will not pay for more than the number of days of care per person, per year shown on the attached Schedule of Benefits. We will not pay for custodial care as defined in Section One above.

## SECTION FOUR - MEDICAL SERVICES

1. **Medical Services Generally.** Under this Section, we will provide coverage for the medical services listed. For purposes of Paragraphs 2-4 below in this Section, Medical Services means care provided by your PCP and the PCP's staff, care provided by the following other Participating Providers when authorized in advance by your PCP: physician, osteopath, optometrist, podiatrist, chiropractor, physical therapist, certified nurse-midwife practicing under qualified medical direction in conjunction with a facility licensed under Article 28 of the Public Health Law of New York State, speech-language pathologist or audiologist, or licensed independent laboratory. We will also pay for services of non-participating medical professionals to whom your PCP refers you when the PCP has first obtained our approval to do so.
2. **Medical Services While Hospitalized.** During any period of hospitalization for which we provide care under Section Three, you will be entitled to the service of a Participating Physician and other Participating personnel, including surgical services, if the service is performed, or prescribed or authorized in advance, by your PCP. However, if two or more surgical procedures are performed through the same incision, we will only pay for the procedure with the highest fee schedule amount. If two or more procedures are performed through different incisions at the same operation, we will pay for the procedure with the highest fee schedule amount and 50% of the fee schedule amount for the other procedures.

**Breast Reconstruction Surgery.** Coverage of surgical services includes: all stages of reconstructive surgery on a breast on which a mastectomy has been performed; reconstructive surgical procedures on the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. This coverage will be provided in a manner determined in consultation with the Attending Physician and you.

3. **Office Visits.** You are entitled to the following medical services:
  - A. **Preventive Health Services.** All necessary health education and counseling services. Also included are: physical examinations; well child care; clinical laboratory and radiological screening tests such as screenings for colorectal cancer, hypercholesterolemia, diabetes mellitus for women who are pregnant or contemplating pregnancy, when the screenings are provided according to nationally recognized criteria; and immunizations.
  - B. **Diagnosis and Treatment.** Services of PCPs and other Participating medical personnel for diagnosis and treatment of disease, injury, or other conditions. This includes surgical procedures and consultations with specialists. Coverage is also available for up to 30 visits per member per year for physical therapy and 30 visits per member per year for occupational and/or speech and/or vision therapy and is subject to the following conditions:
    - The therapy must be skilled therapy. Skilled therapy is therapy which must be furnished by skilled licensed medical personnel in order to assure your safety and achieve the medically desired result.
    - The therapy must be short term and reasonably expected to improve or restore your bodily functions within a reasonable and generally predictable

period of time (usually not more than 60 days). We will not pay for maintenance therapy or therapy designed only to prevent further deterioration.

- We must certify the services in advance.

The 30/30 visit limits include, and are not in addition to, therapy services under Section Three, Paragraph 2 above.

- C. **X-Ray and Laboratory Services.** X-ray and laboratory tests and services. This includes prescribed diagnostic x-rays, x-ray therapy; fluoroscopy; electrocardiograms; laboratory tests; and diagnostic clinical isotope services.
- D. **Mammography Screening.** We will pay for mammography screening for occult breast cancer as follows:
- Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer;
  - A single baseline mammogram if you are age 35 through age 39 inclusive;
  - A mammogram every 2 years, or more frequently upon the recommendation of a physician, if you are age 40 through 49 inclusive; and
  - An annual mammogram if you are age 50 and older.

“Mammography Screening” shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

- E. **Radiation Therapy and Chemotherapy.** We will pay for radiation therapy and chemotherapy.
- F. **Medications for Use in the Office.** Medications, injectables excluding self-injectables, radioactive materials, dressings and casts, used by your PCP or other Participating Provider in the physician’s or provider’s office for preventive or therapeutic purposes.
- G. **Obstetrical and Gynecological Services.** The full range of obstetrical services, including prenatal visits and postnatal visits, and all of the other services set forth above, will be provided with respect to pregnancy. However, we will not pay for any services in connection with artificial insemination or assisted reproductive technology unless otherwise required by law. If you join the HMO after the first trimester of pregnancy, you may continue services from a non-participating physician. You do not need your PCP’s authorization when care is provided by a qualified Participating Provider of obstetric and/or gynecologic services.

You may also receive the following services from a qualified Participating Provider without your PCP’s authorization:

- Up to two (2) annual examinations for primary and preventive obstetric and gynecologic care; and
- Obstetric and gynecologic care required as a result of such annual examinations or as a result of an acute gynecologic condition. The Participating Provider must discuss the services and treatment plan with your PCP according to the HMO’s requirements.

- H. **Allergy Testing and Treatment.** All tests to determine the nature of allergies and desensitization treatments to alleviate allergies, including test or treatment materials.
- I. **Second Surgical Opinion.** If you request a second opinion, we will provide a second surgical opinion if:
- Your PCP recommends that surgery be performed; and  
The second surgical opinion is rendered by a Participating Physician who is a board certified specialist and who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed; and
  - The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Certificate if such surgery were performed; and
  - The specialist who renders the second opinion does not also perform the surgery for which the second opinion was obtained.
- J. **Diabetes Equipment, Supplies and Education.** We will pay for the following equipment and supplies provided by Participating Providers when recommended or prescribed for the treatment of diabetes by a Participating Physician or other Participating Provider authorized by law to prescribe (“Authorized Participating Providers”):
- Blood glucose monitors and blood glucose monitors for the legally blind;
  - Test strips for glucose monitors; and visual reading and urine testing strips;
  - Data management systems;
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices;
  - Oral agents for controlling blood sugar; and
  - Additional medically necessary equipment and supplies, as may be required by the New York State Department of Health.
- We will also pay for diabetes self-management education and diet information provided by Participating Physicians or Authorized Participating Providers, or their staffs, in connection with medically necessary visits, upon the diagnosis of diabetes, a significant change in the patient’s symptoms, the onset of a condition necessitating changes in self-management, or where re-education is medically necessary as determined by us. When such education is provided as part of the same office visit as diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. We will also pay for home visits, when medically necessary.
- Education is also covered when provided by the following Participating Providers upon referral from a Participating Physician or Authorized Participating Provider: Certified Diabetes Nurse Educator, Certified Nutritionist, Certified Dietician, Registered Dietician or other provider required by law. Such education must be provided in a group setting, when practicable.
- K. **Second Medical Opinions Concerning Cancer Diagnoses.** We will pay for an office visit and related diagnostic tests in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when the member is diagnosed by

the member's physician as having some form of cancer. A negative diagnosis of cancer occurs when the member's physician performs a cancer screening exam on the member and finds that the member does not have cancer, based on the exam results. We will also pay for a second medical opinion concerning any recommendation for a course of treatment for cancer. The specialist rendering the second medical opinion will include, but not be limited to, a specialist affiliated with a specialty care center for the treatment of cancer and must be a participating specialist to whom the member received an approved PCP referral, unless the member received an approved PCP referral to a non-participating specialist which shall be at no additional cost to the member.

L. **Chiropractic Care.** We will provide services in connection with the detection and correction (by manual or mechanical means) of:

- structural imbalance; or
- distortion; or
- subluxation;

in the human body for the purpose of removing nerve interference and the effects thereof. This includes cases when the nerve interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

#### 4. **Services in Your Home.**

A. **Visits by your PCP.** In unusual circumstances your PCP may provide care in your home if the home visit is Medically Necessary.

B. **Visits by Participating Home Health Agency Personnel.** We will provide up to 200 visits per calendar year for visits by participating Home Health Agency personnel in your home if we determine that the visit is Medically Necessary and pre-certify the visit(s). The visit may include the following care:

- Part-time or intermittent skilled home nursing care by or under the supervision of a registered nurse. We do not cover full-time or 24 hour per day nursing.
- Part-time or intermittent home health aide services which consist primarily of caring for you.
- Physical, occupational or speech therapy if provided by participating Home Health Agency personnel approved by your PCP.
- Medical supplies, drugs and medications furnished in connection with a visit by medical professionals or participating Home Health Agency personnel.

Part-time or intermittent means at scheduled intervals for a few hours a day and/or several times per week as documented in an established treatment plan. Each visit by a member of the home health care team constitutes one visit. However, a visit by a home health aide is up to 4 hours of covered care.

5. **Copayments.** Each person covered under this Certificate is obligated to pay a copayment each time the person receives covered medical services from a Participating Physician or other Participating Provider in the office, in the person's home or in another ambulatory setting other than a hospital emergency room. However, you do not have to pay a copayment for:
- Routine well-child visits for children from the date of birth through the attainment of 19 years of age which are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Immunizations are included.
  - Maternity care visits.
  - X-ray and laboratory services.
  - Second surgical opinion.
  - Home visits described in Paragraph 4.B. above.
  - Visits exclusively for treatment of allergies.
  - Chemotherapy and radiation therapy.

The amount of the copayments, which will be determined by us from time to time, is set forth on the attached Schedule of Benefits.

6. **Durable Medical Equipment, Prosthetic and Orthotic Appliances, Medical Supplies.** We will pay for medically necessary durable medical equipment, prosthetic and orthotic appliances, and medical supplies, which are ordered by your PCP. Durable medical equipment must be the kind used for a medical purpose, as opposed to a comfort purpose. We will determine whether the equipment should be purchased or rented. We will pay for replacement of durable medical equipment when ordered by your PCP in cases of wear, damage or changes in your condition or body structure; and we will pay for repairs and maintenance of covered equipment which has been purchased. The equipment we will pay for includes items such as: an apnea monitor, wheelchair, hospital type bed, oxygen and oxygen equipment. We will not pay for air conditioners, humidifiers, commodes, dehumidifiers, air purifiers, exercise equipment or swimming pools.

We will pay for prosthetic and orthotic appliances that replace or support all or part of a body function or organ. We will also pay for replacement, repair, fitting and adjustment of the appliances. Included, for example, are: artificial arms, legs and terminal devices (such as hands or hooks); artificial eyes, ears, nose, larynx and external breast prostheses; ostomy sets and accessories; prescription lenses when you lack an organic lens; rigid or semi-rigid supporting devices and appliances essential for the effective use of an artificial limb; corrective braces. We will not pay for arch supports, orthotics used solely for sports or myoelectric or bionic prostheses.

We will pay for medical supplies for use in connection with your illness or injury such as: surgical dressings, splints, ostomy supplies. Common first-aid supplies are excluded.

The covered durable medical equipment, prosthetics, orthotics and medical supplies must be obtained from Participating Providers.

## SECTION FIVE - CASE MANAGEMENT PROGRAM

1. **Case Management.** MMP will perform case management if you have a chronic debilitating or catastrophic injury or illness by providing assistance with and/or explanation of treatment decisions.
2. **Alternative Benefits.** Notwithstanding any other provision in this Certificate, we may review your health status and your Participating Physician's plan of care to determine whether certain levels of care, providers or services which are not included in your Certificate may be desirable or appropriate.

We may make available alternative care which, in our judgment is more appropriate in place of inpatient care. The provision of these services is a substitute for the services provided in your Certificate. You may reject or discontinue our proposal of any alternative care at the time of the proposal or at any time thereafter.

You agree that we may have access to and review on a concurrent basis any of your hospital and other medical records to evaluate alternative care possibilities.

You understand and agree that any proposal of alternative care is limited to the facts and circumstances of the particular case reviewed and does not apply to any other case of yours or to any other HMO member.

3. **Termination of Program Participation.** Either you or we may terminate participation in the Case Management Program at any time for any reason. We will give you at least ten (10) days written notice of our intention to terminate the provision of any alternative or additional care under this Section. After such termination, we will provide services, if available, to you under the terms and conditions of your Certificate.

## SECTION SIX - TREATMENT OF ALCOHOLISM, SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS

1. **Care Must be Referred by Our Mental and Behavioral Health Care Manager.** Under this Section, we will only provide coverage when you are referred for care by our Mental and Behavioral Health Care Manager. You can obtain a referral in one of two ways:
  - Call the 1-800 number shown on the back of your identification card. This toll free number can be called 24 hours a day, seven days a week; or
  - Call or visit your PCP. The PCP will coordinate your referral with the manager.

You must obtain the referral in writing, in advance. If you cannot do so due to an Emergency, you or a member of your family must obtain the referral within twenty-four (24) hours after you receive the care or as soon as is reasonably possible.

- 2. Mental Health Care.** We will pay for a limited number of visits for the outpatient treatment of mental and nervous conditions. The services may be provided by participating medical professionals within the scope of their practice or in the outpatient department of a Participating Hospital or other participating Facility. You must pay the amount shown on the attached Schedule of Benefits for each visit. The visit limit is also shown on the Schedule.

We will pay for inpatient psychiatric care. We will only pay for the number of days shown on the attached Schedule of Benefits. You must pay the inpatient copayment shown on the Schedule of Benefits.

- 3. Treatment of Alcoholism and Substance Abuse.** Coverage is provided for the outpatient diagnosis and treatment of alcoholism and/or substance abuse for 60 visits per person per calendar year. Up to 20 of the 60 visits may be used for family therapy. Family members eligible for family therapy are those persons covered under the same Certificate of family coverage that covers the person receiving, or in need of, treatment of alcoholism or substance abuse. Benefits for these family therapy visits are limited to one visit per day and are available even if the person in need of treatment has not yet begun that treatment. You must pay the amount shown on the attached Schedule of Benefits for each visit.

We will provide short-term inpatient care for alcoholism and/or substance abuse for 7 days per calendar year. You must pay the inpatient copayment shown on the attached Schedule of Benefits.

## **SECTION SEVEN - EMERGENCY CARE**

- 1. Emergency Care.** We will pay for Medically Necessary care for an Emergency as defined above. If the care is received in a hospital emergency room, you must make a copayment unless you are admitted to the hospital for treatment of the same illness or injury within one day. The amount of the copayment will be determined by us from time to time and is shown on the attached Schedule of Benefits.

We will pay for Medically Necessary emergency care even if you do not call your PCP in advance. However, you or a member of your family must call your PCP or us within twenty four (24) hours after you receive care or as soon as it is reasonably possible.

We will pay for emergency care rendered by non-participating providers, including non-participating hospitals. However, if you are admitted to a non-participating hospital, we will only pay for the care for as long as we determine that the hospitalization was Medically Necessary and that your condition prevented transfer to a Participating Hospital. We can require that you be transferred to a Participating Hospital when medically appropriate.

Care received in a hospital emergency room that is not for an emergency as defined in Section One above is not covered, unless your PCP approves it.

- 2. Ambulance Service.** If in our judgment you required emergency transportation by ambulance, we will pay for the ambulance service. MMP must preauthorize transportation by an air ambulance.

3. **Urgent Care.** Urgent care is care which is required in order to prevent serious deterioration to your health; but it is not life or limb threatening. The need for urgent care is less than the need for emergency care but it is the kind of care that needs timely attention. Examples of urgent medical problems are: bronchitis, nosebleed, fever, otitis media, sprained ankle, viral syndrome. Except as provided in the following paragraph, your PCP must provide or authorize urgent care in advance.

**Urgent Care When Traveling or Visiting.** We will pay for urgent care provided to you when you are traveling or visiting outside of our Service Area or are more than 100 miles away from your PCP - that is, you are temporarily out of our Service Area, or a long distance away from your PCP. When you need urgent care under these circumstances you may call 1-800-4HMO-USA for a referral to a local provider. Or you may call your PCP for prior authorization of urgent care and follow his or her instructions. We will not pay for care which, in our sole judgment, was not needed for an urgent condition.

## **SECTION EIGHT - HOSPICE CARE**

1. **Eligibility for Benefits.** To obtain hospice care, you must meet both of the following conditions:
  - A. Your PCP estimates your life expectancy to be six months or less.
  - B. Palliative care (pain control and symptom relief), rather than curative care, is being provided.
2. **Hospice Organizations.** We will only pay for hospice care provided by a Participating Hospice. A Participating Hospice is a hospice which has an agreement with us to provide services to persons covered under our HMO contracts. Your admission must be authorized by your PCP, preauthorized by MMP and you must be under the care of Participating Providers while you are in the hospice.
3. **Hospice Care Benefits.** We will pay for the following services when provided in the Participating Hospice.
  - A. Bed patient care provided by the Hospice organization either in a designated Hospice unit or in a regular hospital bed.
  - B. Day care services provided by the Hospice organization.
  - C. Home care and outpatient services which are provided and billed through the Hospice, including drugs and medical supplies. We will also pay for bereavement services provided to your family during illness, and until one year after death.
  - D. Palliative care. We will also pay for medical care outside the Hospice provided or authorized by your attending physician.

- 4. Number of Visits.** We will pay for up to 210 days of hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. We will also pay for no more than 5 visits for bereavement counseling services to your family, either before or after your death.

## **SECTION NINE - EXCLUSIONS**

In addition to certain exclusions and limitations already described in this Certificate, we will not pay under this Certificate when any of the following apply to you:

- 1. Medically Unnecessary Care.** We will not pay for any treatment, service or supply that we determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns our denial, however, we shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Certificate. (For further information on external appeals, consult your Member Handbook).
- 2. Care by Non-Participating Providers.** Except in an emergency, we will not pay for care rendered by non-participating providers.
- 3. Care Provided Outside of the HMO Service Area.** With the exception of emergency care and urgent care covered under Section Seven, we will not pay for services provided to you when you are visiting, traveling, or temporarily residing, outside of the 28 county HMO Service Area. Out-of-area care is also covered under the HMO-USA Guest Membership Program (see Section Fifteen, Paragraph 13).
- 4. Government Hospital.** We will not pay for care in any hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the hospital is a participating hospital. However, this exclusion does not apply to United States Veterans Administration or Department of Defense hospitals, except for services in connection with a service-related disability. In addition, we will pay for care covered under this Certificate in such a hospital if, because of serious injury or sudden illness, you are taken to one of these hospitals for emergency care because it is close to the place where you were injured or became ill. In this type of emergency situation, we will continue to make payments only for as long as emergency care, in our sole judgment, is necessary and it is not possible for you to be transferred to another hospital.
- 5. Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.
- 6. Free Care; Care Provided by Family Members.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge if you were not covered under this Certificate or under any other insurance. This also applies even if the charges are billed. We will not pay for services rendered by a member of your immediate family.

7. **Government Programs.** We will not pay for any service which is covered, and payment is therefore available to you, under any federal, state or local government program, except that we will pay even though you are eligible for Medicaid.
8. **Custodial Care.** We will not pay for hospital care, nursing home or skilled nursing facility care, home care or any other service which is custodial care.
9. **Unauthorized Services.** Except for obstetrical and gynecological services described in Section Four, Paragraph 3.G. and emergency care described in Section Seven, we will not provide benefits for any service or care unless treatment is performed, or prescribed, arranged or authorized in advance, by your PCP and, when required, approved in advance by us.
10. **Cosmetic Surgery.** No benefits are provided for any services in connection with elective cosmetic surgery or any hospitalization in connection with such surgery. However, benefits may be available for reconstructive surgery if it is necessary to treat an infection or injury. With respect to a covered child, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.
11. **Admission to a Hospital Before You Become Covered Under This Certificate.** If you are admitted to a hospital or skilled nursing facility as a registered bed patient before the date you become covered under this Certificate we will not pay for any part of your stay in that hospital or skilled nursing facility or for medical services related to that stay, to the extent that you have coverage under any other contract or policy of insurance, including provisions for benefits after termination in the event of disability. In addition, we will not pay for any part of the stay if your care is not transferred to and authorized by your PCP.
12. **No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.
13. **Dental Care.** We will not pay for dental surgery or anesthesia, or dental treatment of any kind including: treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; treatment of dental temporo-mandibular joint syndrome, dental implants; orthognathic surgery for the purpose of aligning the teeth; or any other dental services you may receive. We will, however, pay for any service we cover under this Certificate in connection with an accidental injury to sound natural teeth if the service is performed within 12 months of the accident.
14. **Hearing Aids.** We will not pay for hearing aids or artificial aids, including examinations for, or fitting of, the hearing or artificial aid.
15. **Routine Care of Feet.** We will not pay for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will pay for Medically Necessary capsular or bone surgery related to bunions or hammertoes. Orthotics are excluded.

**16. We will not pay for any service, treatment or procedure in connection with any of the following:**

- Examinations required by a third party, such as your employer, school or camp.
- Required for a condition arising out of: participation in a felony; suicide; attempted suicide; intentionally self-inflicted injury; or war or act of war, whether declared or undeclared. However, we will pay for mental care in connection with attempted suicide.
- Weight loss counseling, except when provided by your PCP.
- Surgery for treatment of obesity for purposes of weight reduction, including gastric stapling, gastric by-pass, gastric bubble and any other surgery we determine to be medically inappropriate for treatment of obesity.

**17. Eyeglasses.** We will not pay for: eyeglasses; or the fitting of, or examination of the eye for, glasses or contact lenses, except when Medically Necessary, in our judgment, following cataract surgery.

**18. Benefits for Medicare Eligibles Who Are Covered Under This Certificate.**

- A. If your group has twenty (20) or more employees, any active employee or spouse of an active employee who becomes or remains a member of your group covered by this Certificate after becoming eligible for Medicare due to reaching age sixty-five (65) will receive the benefits of this Certificate as primary; unless Medicare is elected as the primary coverage. When Medicare is elected as primary, coverage under this Certificate will end.
- B. If your group has one hundred (100) or more employees or your group is an organization which includes an employer with one hundred (100) or more employees, any active employee, spouse of an active employee or dependent child of an active employee who becomes or remains a member of your group covered by this Certificate after becoming eligible for Medicare due to disability will receive the benefits of this Certificate as primary; unless Medicare is elected as the primary coverage. When Medicare is elected as primary, coverage under this Certificate will end.
- C. If you have end stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective, your coverage under this Certificate will be primary during the waiting period. It will also be primary during the coordination period with Medicare. After the coordination period, Medicare is primary.
- D. If you are a retiree or an active employee or spouse of an active employee who is not subject to Paragraphs A or B above and who is Medicare eligible you will continue to receive the benefits of the Certificate. We will file the appropriate forms with Medicare so that the Medicare benefits will be applied to defray the premium cost of the HMO program. You must enroll in Medicare, sign any claim forms or other documents which are necessary for us to obtain payments from Medicare for services provided to you through the HMO. If you do not

enroll or do not sign the forms or other documents and submit them to us, we have the right to deny HMO payments for the service.

**19. Treatments, Procedures, Hospitalization, Drugs, Biological Products or Medical Devices Which are Experimental or Investigational.**

We will not cover any treatment, procedure, drug, biological product or medical device (hereinafter “technology”) or any hospitalization in connection with such technology if, in our sole discretion, it is not Medically Necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

- A. not of proven benefit for the particular diagnosis or treatment of your particular condition; or
- B. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

We will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

We may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

- any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.
- conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable;

- proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

This exclusion does not apply to cancer drugs as required by Section 4303(q) of the New York State Insurance Law.

However, we shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non-investigational treatments provided in such clinical trial. (For further information on external appeals, consult your Member Handbook.)

- 20. Donor Fees; Transportation.** We will not pay for donor fees and transportation costs in connection with non-experimental organ transplants.
- 21. Drugs.** We will not pay for prescription drugs, over-the-counter drugs which do not require a prescription, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication except drugs provided on an inpatient basis or pursuant to Section Four, Paragraph 3.F. and diabetes equipment and supplies pursuant to Section Four, Paragraph 3.J.
- 22. Pre-existing Conditions.** We will not pay for any pre-existing conditions until you have been enrolled under this Certificate for at least 11 consecutive months. A pre-existing condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on your enrollment date under this Certificate. For purposes of this section, "enrollment date" means the first day of your coverage under this Certificate or, if earlier, the first day of any waiting period that must pass before you are eligible to be covered for benefits under this Certificate.

Genetic information will not be treated as a pre-existing condition unless you have been diagnosed with a condition related to such information.

This exclusion for pre-existing conditions does not apply:

- A. If, on the last day of the 30 day period beginning on the date of birth, you are covered under Creditable Coverage as defined below.
- B. To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30 day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage as defined below.
- C. In the case of pregnancy.

Paragraphs A and B will not apply after the end of the first 63 day period during all of which you were not covered under any Creditable Coverage.

“Creditable Coverage” means your coverage under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or B of title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under chapter 89 of title 5, United States Code;
9. A public health plan (as defined in regulations);
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

In determining whether this pre-existing condition provision applies, we will credit the time you were previously covered under Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than 63 days prior to your enrollment date under this Certificate. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective will also be credited.

This exclusion does not apply if your group has more than 50 members.

- 23. Services of Unlicensed Providers.** We will not pay for services provided by an unlicensed provider or services that are outside the scope of the license of a licensed provider.
- 24. Private Duty Nursing Services.** We will not pay for private duty nursing services.
- 25. Assisted Reproductive Technologies.** We will not pay for reversal of sterilization or artificial insemination. Also excluded are: in-vitro fertilization; gamete intrafallopian tube transfer; zygote intrafallopian tube transfer; intracytoplasmic sperm injection; or other forms of assisted reproductive technology, unless otherwise required by law. We will not pay for cryopreservation of sperm or embryos.
- 26. Services by Employees of Facilities.** We will not pay for services performed by staff employed by a Hospital or other Facility where you receive care.

## SECTION TEN - COORDINATION OF BENEFITS

1. **Applicability.** This Section applies only to subscribers and members of their families covered under “THIS PLAN” who also have group health benefits coverage with another “Plan.” (The terms “THIS PLAN” and “Plan” are defined below.) When that is the case and you receive an item of service, we will coordinate benefit payments with any payment made under the other Plan. One will pay its full benefit as the primary plan and the other may pay secondary benefits, if necessary, to cover some or all of your remaining expenses. This prevents duplicate payments and overpayments.
2. **Definitions.**
  - A. “THIS PLAN” is this certificate of coverage.
  - B. “Plan” is another group health benefits program with which we will coordinate benefits. The term “Plan” includes:
    - Group health benefits and group, blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid group coverage but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premium.
    - Medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.
      - Hospital, medical and surgical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. It also does not include any plan whose benefits are by law excess to any private insurance program or other non-governmental program.
3. **Rules to Determine Payment.** The first of the rules listed below (A-F) which applies shall determine which plan shall be primary:
  - A. If the other Plan does not have a provision similar to this one, then it shall be primary.
  - B. If you, the person receiving the benefits, are the person belonging to the group through which, or to which, THIS PLAN was issued and you are only covered as a dependent under the other Plan, THIS PLAN will be primary.
  - C. If a dependent child is covered under plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. However, if the other Plan does not have this (“birthday”) rule but instead has a rule based on the gender of the parent and as a result the plans do not agree on which is primary, then the father’s plan shall be primary.

- D. If a dependent child is covered by both parents' plans, the parents are separated or divorced and there is no court decree which establishes financial responsibility for the child's health care expenses:
- i. the plan of the parent who has custody (the custodial parent) shall be primary;
  - ii if the custodial parent has remarried, and the child is also covered as a dependent under the stepparent's plan, the custodial parent's plan shall pay first, the stepparent's plan second and non-custodial parent's plan third.

If a court decree specifies which parent is to be responsible for the child's health care expenses and that parent's plan has actual knowledge of the decree, then that parent's plan shall be primary.

- E. If you are covered under one plan as an active employee (e.g., not laid-off or retired), or as the dependent of such an active employee and you are covered under another plan as a laid-off or retired employee or as the dependent of such a laid-off or retired employee, the plan which covers you as an active employee, or as the dependent of such an active employee, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- F. If none of the above rules determines which plan shall be primary, the plan which covered you for the longer period of time shall be primary.
- 4. Effects of Coordination.** When THIS PLAN is secondary, the benefits of THIS PLAN will be reduced by the amount paid or provided by the primary plan(s) for the same item of service. The amount THIS PLAN will pay or provide will not be more than the amount it would pay or provide if it were primary. The benefits of THIS PLAN plus those of the primary plan will be less than your total expenses for an item of service unless the primary plan by itself provides benefits at 100% of your expenses.
- 5. Private Room Differential.** Regardless of whether THIS PLAN is primary or secondary, THIS PLAN will not pay or provide benefits for the difference between the cost of a private hospital room and the cost of a semi-private hospital room unless a private room is Medically Necessary in terms of generally accepted medical practice and covered under Section Three, Paragraph 4 of this Certificate.
- 6. Right to Receive and Release Necessary Information.** We have the right to release or obtain information which we need to carry out the purpose of this Section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not, we have the right to deny payments to you.
- 7. Payments to Other Plans.** We may repay to any other plan the amount which it paid for your expenses and which we decide we should have paid. These payments are the same as benefits paid to you and they satisfy our obligation to you under THIS PLAN.

8. **Our Right to Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, you agree to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover any overpayment from the other plan and you agree to sign all documents necessary to help us recover any overpayment.
9. **Coordination with “Always Excess,” “Always Secondary” or “Non-Complying” Plans.** We will coordinate benefits with plans which provide benefits which are always excess or always secondary or use order of benefit determination rules which are inconsistent with those described above (“non-complying plans”) in the following manner:
  - A. If THIS PLAN is primary, it will pay or provide benefits first;
  - B. If THIS PLAN is secondary, we will still pay or provide benefits first, but the amount paid or benefits provided will be limited to what we will pay or provide if we were secondary; and
  - C. If we request information from a non-complying plan and do not receive it within 30 days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying plan and THIS PLAN provide identical benefits. When the information requested is received, we will make the necessary adjustments.

#### **SECTION ELEVEN - PREMIUMS FOR THIS COVERAGE**

1. **Amount of Premiums.** The premiums for this coverage are determined by us from time to time. The premiums must also be approved by the Superintendent of Insurance of the State of New York. The premiums may vary for the different geographic regions served by the HMO. If you move from one region to another or change PCPs the premium rate for your coverage may change.
2. **Change in Premiums.** If there is to be either an increase or a decrease in the premiums for this coverage, we will give you written notice that there will be a change at least 15 days before the new premiums go into effect.
3. **Payment of Premiums and Grace Period.** All premiums for this coverage are due in advance. However, we allow a 15 day grace period for the payment of all premiums, except the first premium. This means that, except for the first premium, if payment is made to us within 15 days of the date the payment was due, we will continue coverage under this Certificate for the entire period covered by the payment. If payment is not made within the 15 day grace period, your coverage under this Certificate will terminate as of the date to which premium was paid. You will not become covered under this Certificate until the first premium payment has been paid to us.

## SECTION TWELVE - TERMINATION OF YOUR COVERAGE

Described below are reasons why your coverage under this Certificate may terminate.

- 1. Default in Payment of Premiums.** Your coverage will automatically terminate as of the date to which the premium was paid if we do not receive your premium by the end of the 15 day grace period. If the premium is not paid by the end of the 15 day grace period, we will not make payments under this Certificate for any service given to you after the date to which the premium was paid. For example, if the premium is due on June 1 and it is not paid by June 15, the end of the 15 day grace period, and premium was paid to June 1, no payment will be made under this Certificate for any services given to you after June 1. However, if you are totally disabled on the date your coverage terminates you may be entitled to have your benefits continued (see Paragraph "8" below). If you receive care from a Participating Physician following the date your coverage terminates, you must pay the physician at his or her normal charges.

If Empire accepts your payment after you have failed to make a timely premium payment and the grace period has expired, your contract will be reinstated, but only to cover such sickness and injury as may be first manifested more than ten days after the date of such acceptance.

**Reinstatement Fee.** At our sole option we may reinstate your coverage after it has terminated due to non-payment of premium. If we decide to reinstate your coverage, we reserve the right to charge a reinstatement fee in addition to requiring that all outstanding premiums be paid. Reinstatement of your coverage on one occasion does not apply to any other case of yours or any other HMO member.

- 2. If You are No Longer Covered in a Group.** This coverage will terminate on the date indicated if one of the following happens:
  - A. On the date to which your premium is paid if you are no longer a member of the group. For example, if your employment in the group terminates on May 15 and your premium has been paid to June 1, this coverage will terminate on June 1.
  - B. On 30 days prior written notice if the size of your group no longer meets our requirements. We will notify you if this happens. For example, if we notify you on May 15 that the size of your group no longer meets our requirements, this coverage will terminate on June 15.
  - C. On the date to which your premium is paid if your employer, or other organization which sends your premium to us, tells us it will no longer send in the premiums for the group. For example, if we are notified by your employer on May 15 that the employer will no longer send in your premium and your premium is paid to June 1, this coverage will terminate on June 1.
- 3. When you Become Eligible for Medicare.** Coverage of any person under this Certificate will automatically terminate if under the Tax Equity and Fiscal Responsibility Act of 1982, or the Omnibus Budget Reconciliation Act of 1986, and subsequent amendments you have an option to either remain covered by this Certificate or be covered by Medicare, and you elect Medicare as the primary coverage.

4. **On Your Death.** Coverage will automatically terminate on the date of your death. However, if you have family coverage, this coverage will terminate on the date to which the premium has been paid.
5. **Termination of Your Marriage.** If you become divorced or your marriage is annulled, the coverage of your wife or husband will automatically terminate on the date of the divorce or annulment.
6. **Termination of Coverage of a Child.** The coverage of your child under this Certificate will automatically terminate when the child marries, becomes the age shown on the Schedule of Benefits, whichever comes first, or is no longer an unmarried full-time student under the age shown on the Schedule of Benefits at an accredited institution. The coverage will terminate as of December 31st of the calendar year in which the child no longer meets these conditions, or date of marriage, whichever occurs first.

If the child is covered under Section Two of this Certificate because the child is unable to work or support himself, coverage will terminate on the date the child is no longer incapable of self-support.

7. **Termination and Nonrenewal.** Except as described above, your coverage under this Certificate will be renewed and continued in force. However, we may nonrenew or discontinue coverage under a group contract based only on one or more of the following:
  - A. The contract holder or participating entity has failed to pay premiums or contributions in accordance with the terms of the contract or we have not received timely premium payments.
  - B. The contract holder or participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
  - C. We cease to offer group or blanket policies in a market in accordance with this provision.
  - D. The contract holder ceases to meet the requirements for a group under Section 4235 of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the policy is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.
  - E. Where we offer a group policy in a market through a network plan, there is no longer any member in connection with such plan who lives, resides or works in our Service Area.
  - F. Such other reasons as are acceptable to the Superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

In any case where we decide to discontinue offering a particular class of group HMO contract offered in the small or large group market, the contract of such class may be discontinued if:

1. We provide written notice to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage.
2. We offer to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other HMO coverage currently being offered by us to a group in such market.
3. In exercising the option to discontinue coverage of this class and in offering the option of coverage under item 2 above, we act uniformly without regard to claims experience of those contract holders or any health status - related factor relating to any members covered or any new members who may be eligible for coverage.

In any case in which we elect to discontinue offering all HMO coverage in the small group market or the large group market, or both markets, in the state, coverage may be discontinued only if:

1. We provide written notice to the Superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage.
2. All HMO coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and
3. We provide the Superintendent with a plan to minimize potential disruption in the marketplace occasioned by the discontinuance.

At the time of coverage renewal, we may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law and effective on a uniform basis among all small contract holders with the contract form. The coverage renewal date is the anniversary of the effective date of the group contract.

8. **Benefits After Termination.** If you are, in our sole judgment, totally disabled on the date your coverage under this Certificate terminates, and you receive service or care for the illness, condition or injury which caused your total disability, we will continue to pay for your care under this Certificate during an uninterrupted period of total disability until the first of the following dates:
  - A. A date you are, in our sole judgment, no longer totally disabled.
  - B. A date twelve months from the date this Certificate terminates or your coverage under this Certificate terminates.

However, we will not pay for more than you would have been entitled to receive if your coverage under this Certificate had not terminated; and we will not provide benefits after termination if you have coverage for the total disability under another group plan.

- 9. Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most group health plans sponsored by employers with 20 or more employees must offer employees and their dependents the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If you are not entitled to temporary continuation of coverage under COBRA (for example, because your employer has less than 20 employees) you may be entitled to continuation of coverage under the provisions of the New York State Insurance Law as described in Paragraph 10 below. Call or write your employer or us to find out if you are entitled to continuation of coverage under COBRA or under the New York State Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York State Insurance Law.
- 10. Continuation of Coverage Under New York State Insurance Law.** If you lose coverage under this Certificate because of termination of employment or membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:
- A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage which does not exclude or limit coverage for pre-existing conditions.
  - B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Div. below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage.
  - C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the date coverage would otherwise terminate. The premium cannot exceed 102% of the group's rate.
  - D. Coverage will terminate at the earliest of the following:
    - i. The date 18 months after your coverage would have terminated because of termination of employment or membership.
    - ii. The date to which premiums are paid if you fail to make a timely payment.
    - iii. If you are an eligible dependent, the date 36 months after coverage would have terminated due to: death of the employee or member; divorce or legal separation; the employee or member's eligibility for Medicare; failure to qualify under the definition of "children."
    - iv. The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage. However, if the employee or member is no longer disabled, coverage will terminate at

the later of: the date in “i” above; or the month that begins more than 31 days after the determination that the employee or member is no longer disabled.

- v. The date the group no longer provides coverage to any of its employees or members.

**11. The Right To Convert Coverage When Continued Coverage Ends.** When continued coverage ends, coverage may be converted according to Section Thirteen.

**12. Supplemental Continuation and Conversion.** If your group’s plan qualifies as an employer group health plan subject to the federal continuation of coverage provisions of COBRA as described above in Paragraph 9, the supplementary continuation and conversion rights described in this paragraph do not apply.

If you are a member of a reserve component of the armed forces of the United States, including the National Guard, and enter active duty and you do not voluntarily maintain HMO coverage, coverage shall be suspended unless you elect in writing, within sixty days of being ordered to active duty, to continue coverage under this Certificate for yourself and your eligible dependents. Such continued coverage shall not be subject to evidence of insurability. You must pay the group the required group-rate premium in advance, but not more frequently than once a month.

Supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available to active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

In the event that you are re-employed or restored to participation in the group upon return to civilian status after the period of continuation of coverage or suspension, you shall be entitled to resume coverage under this Certificate for yourself and your eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion shall be imposed in connection with resumed coverage except regarding: a condition that arose during the period of active duty and that has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty.

In the event that you are not re-employed or restored to participation in the group upon return to civilian status, you shall have the right within thirty-one days of the termination of active duty, or discharge from hospitalization incident to active duty which continues for a period of not more than one year, to submit a written request for continuation to the group, or a request for conversion directly to the HMO, as described elsewhere in the Certificate. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available to your spouse if divorce or annulment of the marriage occurs during the period of active duty, and, in the event you die while on active duty, to your spouse and children, and to each child individually upon attaining the limiting age of coverage under this Certificate (but not the child’s dependents).

## SECTION THIRTEEN - RIGHT TO NEW CONTRACT AFTER TERMINATION

If coverage under this Certificate terminates, then under the circumstances described below you may continue coverage with us by purchasing a new contract.

- 1. If You Are No Longer Covered in a Group; or If the Group Defaults in the Payment of Premium.** If coverage terminates under the provisions of Paragraphs “1” or “2” of Section Twelve because your group defaults in the payment of premium or you are no longer a member of a group, you are entitled to purchase a new contract as a direct payment subscriber unless the group has replaced the coverage with similar and continuous coverage.
- 2. On Your Death.** If coverage terminates because of your death, your wife or husband or dependent children are entitled to purchase a new contract as a direct payment subscriber.
- 3. Termination of Your Marriage.** If your coverage terminates because you become divorced or your marriage is annulled, you are entitled to purchase a new contract as a direct payment subscriber.
- 4. Termination of Coverage of a Child.** If your coverage terminates because you become married, reach the age shown on the Schedule of Benefits, or are no longer an unmarried full-time student under the age shown on the Schedule of Benefits, or if you are no longer incapable of self-support, you are entitled to purchase a new contract as a direct payment subscriber.
- 5. When To Apply For The New Contract.** If you are entitled to purchase a new contract, you must apply to us for the new contract within 45 days after notice of termination of coverage under this Certificate is given; or if no notice is given, within 90 days of termination. You must also pay the first premium for the new contract within this same 45 or 90 day period.
- 6. The New Contract.** The new contract will be the standardized HMO contract required to be sold on a direct payment basis. If you prefer, the new contract will be the standardized HMO contract with out-of-plan benefits.

## SECTION FOURTEEN - DISPUTES UNDER THIS CERTIFICATE

- 1. Appeals.** If you are subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections and your group may have duties as the Group Health Plan Administrator. Among them are the right to appeal a claim decision.

Under ERISA, if we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. Then you have sixty (60) days to appeal our decision. You (or your authorized representative) may submit a written request for review. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one hundred

and twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

You may also refer to your Member Handbook for a description of the HMO complaint procedures, including appeals to the HMO Grievance Committee. These procedures apply whether or not you are subject to ERISA.

### **Medical Management Program Appeals**

If we have not made and notified you of an adverse determination, as defined by law, within the specified timeframes, you may request an internal review without waiting for us to make the determination. Also, if you have requested an internal review of an adverse determination, and we have not made and notified you of our review decision within specified timeframes, we are required to cover the service, subject to all other conditions of your coverage.

### **External Appeals**

You have the right to an external appeal of a final adverse determination by Empire that is based on a determination that the requested service is not medically necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determination, even if those other determinations affect your coverage. You may request an external appeal only if the requested service is a covered service under this Contract or Certificate.

- An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal.
- You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.
- You may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination. You or your physician may obtain additional standard request forms at any time from the state Insurance Department, the Department of Health, or by contacting us.
- You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination or within 45 days of receiving a letter from us waiving our internal review process. We do not have the authority to grant extensions of this deadline.

External Appeals Based on Medical Necessity. You may request an external appeal if the final adverse determination indicates that the requested service is not medically necessary.

External Appeals for Determinations Involving Experimental or Investigational Treatment. In order to request an external appeal under this Paragraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A ‘life-threatening condition or disease’ is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A ‘disabling condition or disease’ is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or that no more beneficial standard treatment exists which is a covered service under your plan.

Your attending physician must have recommended a health services or procedure (including off-label usage of a pharmaceutical product), which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

External Appeals of Determination Involving Clinical Trials. In order to request an external appeal under this Paragraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial. Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration or the Department of Veterans Affairs;
- an entity that has been identified by the NIH as a qualified non-governmental research entity; or
- an Institutional Review Board of a facility that has multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the External Appeals Agent decides in your favor, we will cover the service as follows:

- for services denied as not medically necessary, we will treat the service as medically necessary and provide coverage subject to all other conditions of your coverage.
- for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of coverage.
- For services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for and will not pay for, drugs and devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under your Certificate. All other terms of your certificate apply to this section, including any applicable copayments, coinsurance or deductibles.

2. **Choice of Law.** This Certificate has been issued in New York State pursuant to our contract with a group located in New York State. In any dispute between us and the group or you, New York or federal law, as appropriate, shall be applied to determine your rights, the rights of the group, and our rights.
3. **Time To Bring Legal Action; Option of Arbitration.** You must start any lawsuit against us under this Certificate within two years from the date you receive the service for which you want us to pay.

If you would prefer an arbitration proceeding rather than a legal action, we hereby consent to have any and all disputes you may have arising out of, or related to, this Certificate submitted to arbitration under the conditions described below, rather than a court of law. The arbitration shall be conducted pursuant to the rules of the American Arbitration Association. The cost of the arbitration shall be borne equally between you and us. We hereby agree, and you must agree if you choose to initiate the arbitration proceeding, to be bound by the decision of the arbitrator and consent to have judgment upon the arbitration award be entered in any court of competent jurisdiction. The arbitration must be conducted in New York State and according to New York law. You must start any arbitration proceeding against us under this Certificate within two years from the date you received the service which you want us to pay for. The arbitration provision offered in this paragraph is made available under special provisions of the Insurance Law which allow innovative health care coverage to be offered on an experimental basis. Under the Insurance Law this arbitration provision may be terminated at any time, when authorized or required by the Superintendent of Insurance. However, termination of this arbitration provision shall not alter or affect the validity of any decision issued by an arbitrator, or the validity of arbitration procedures already initiated by filing a demand for arbitration, prior to the date any such termination is designated to take effect.

## SECTION FIFTEEN - GENERAL PROVISIONS

- 1. No Assignment.** You cannot assign any benefits or monies due under this Certificate to any person, corporation or other organization. Any assignment by you will be void. assignment means the transfer to another person or to an organization of your right to the services provided under this Certificate or your right to collect money from us for those services.
- 2. Notice.** Any notice which we give to you will be mailed to you at your address as it appears on our records, or if you are covered in a group, in care of your employer or other organization which sends the premium to us. If you have to give us any notice, it should be mailed to our office at Empire HealthChoice HMO, Inc., Church Street Station, P.O. Box 3509, New York NY 10008-3509.
- 3. Your Medical Records.** In order to provide care, address your concerns, respond to grievances, perform utilization review or quality assurance activities or process your claims under this Certificate, it may be necessary for us to obtain your medical records and information from hospitals, skilled nursing facilities, doctors or other practitioners who treated you. When you become covered under this Certificate, you automatically give us permission to obtain and use those records and that information. If you do not furnish us with the records, we have the right to deny payment for that claim.

At any time requested by us, you will provide us with a signed authorization to obtain records we need as referred to above. You hereby authorize us to disclose to a hospital or health care service plan, self-insurer or insurer, any medical information obtained or payments made if such disclosures are necessary to allow the processing of any claim.

You also authorize disclosures to your employer, trust fund, union or similar entity which arranged for this coverage for purposes of utilization review or audit and such disclosures as may be permitted or required by law.

- 4. Changes To This Certificate.** We may change this Certificate at the time the group contract is renewed. We will give you at least 30 days written notice of any change. All care you receive after the effective date of the change will be subject to the change, even if you were receiving care before the change became effective.
- 5. Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided in a participating hospital or by a Participating Physician or Provider will be made by us directly to the Hospital, physician or provider. If you receive service in a non-participating hospital, or from any other provider of care covered under this Certificate, we reserve the right to pay either you or the hospital, or other provider.
- 6. Recovery of Overpayments.** On occasion a payment will be made when you are not covered, for a service which is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return to us within 60 days the amount of the overpayment.
- 7. Furnishing Information and Audit.** The group and all persons covered under this Certificate agree to promptly furnish us all information and records which we may require from time to time to perform our obligations under this Certificate. You also agree to provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized

by your PCP; or to make decisions regarding the medical necessity of your care. The group agrees that upon reasonable notice it will make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group's New York office.

- 8. Enrollment.** The group further agrees to develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all persons covered under this Certificate, and any other information required to confirm their eligibility for coverage. The group agrees to provide us with the Notice of Election including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group fails to so advise us, the group will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 60 days.
- 9. This Certificate Does Not Change a Provider's Usual Procedures.** This Certificate does not change the relationship between a patient and provider or hospital and it does not force a provider or hospital to accept you as a patient. Usual hospital rules apply to the services you receive. We do not guarantee admission to any hospital or that any particular service or accommodation will be available.
- 10. Physical Examination.** We may require you to undergo a physical examination as often as reasonably necessary in connection with any injury or illness which results in a claim under this Certificate.
- 11. Right To Develop Guidelines and Group Administrative Rules.** We may develop or adopt standards which describe in more detail when we will or will not make payments under this Certificate and group administrative rules pertaining to group enrollment and other administrative matters. We have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this coverage, including, without limitation thereto, the power to construe this Certificate, to determine all questions arising under it, and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Certificate. If you have a question about the standards which apply to a particular benefit or the group administrative rules, you may contact us and we will explain the standards or rules.
- 12. Independent Licensee.** Empire HealthChoice HMO, Inc. (Empire) is an independent health maintenance organization organized under the laws of New York State. Empire also operates under licenses with the Blue Cross and Blue Shield Association, the association of independent Blue Cross and Blue Shield plans, which licenses Empire to use the Blue Cross and Blue Shield Service Marks in a portion of New York State. Empire does not act as an agent of the Blue Cross and Blue Shield Association, and Empire is solely responsible for honoring its agreements to provide comprehensive health services plans to its customers.

- 13. Guest Membership.** If you are away from our Service Area for an extended period of time, you may be eligible for Guest Membership at a local HMO which is part of the Blue Cross and Blue Shield Association's national HMO network. Spouses and dependent children must be away for at least 90 days. The Certificate holder must be away at least 90 days, but not more than 180 days. You will have the benefits offered by the local ("Host") HMO, but at no extra charge. Call 1-800-4HMO-USA for information about the Guest Membership program.
- 14. BlueCard Program.** We participate in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. The BlueCard Program gives our members access to care when outside of our Service Area. By presenting your identification card to any Blue Cross and/or Blue Shield participating hospital, physician or other provider outside of our Service Area anywhere in the United States, you are assured that you will receive the covered services you would be entitled to receive within our Service Area and that you will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan. HMO members, however, remain subject to Certificate limitations that apply to coverage outside the Service Area. Member liability for covered services for claims incurred outside our Service Area and processed through the BlueCard Program, in most instances, will be based on the lower of:
- The out-of-area participating provider's actual billed charges for the covered services provided, or
  - The negotiated price for the covered services that the out-of-area Blue Cross and/or Blue Shield Plan passes on to us.

The "negotiated price" will generally consist of (a) a simple discount to the participating provider's billed charge; or (b) an estimated final price that factors in expected settlements or other non-claims transactions with the out-of-area provider or specified group of providers; or (c) a discount from billed charges that reflects average expected savings. Plans which use estimated or average prices may also periodically adjust their future estimated or average prices to correct for over- or underestimation of past prices.

Some Blue Cross and/or Blue Shield Plans charge an access fee for making their negotiated rates and the resulting savings available on claims processed through the BlueCard Program. This fee is not included in the negotiated price that is the basis for member liability, but rather is paid by us when the claim is finalized.

In addition, laws in a few states require Blue Cross and/or Blue Shield Plans to calculate member liability for covered services based on a method that does not reflect the entire savings realized or expected to be realized on a particular claim. Thus, when our members receive covered services in those states, their member liability for covered services will be calculated using the applicable state's statutory methods.