NYC EMPLOYEES PPO PLAN
NEW YORK NY

Health Benefit Summary Plan Description
7670-00-417151

BENEFITS ADMINISTERED BY

EmblemHealth | UnitedHealthcare

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NYC EMPLOYEES PPO PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the **NYC Employees PPO plan** (the "Plan"). You are a Member of **NYC Employees PPO plan**, and the City of New York is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs.

The City, acting through the Mayor's Office of Labor Relations ("OLR"), is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are EmblemHealth | UnitedHealthcare (hereinafter "EmblemHealth | UnitedHealthcare") for medical claims, and Prime Therapeutics for pharmacy claims, as a subcontractor of EmblemHealth. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The City assumes the sole responsibility for funding the Plan benefits out of general assets; however, Members help cover some of the costs of covered benefits through contributions, Deductibles, Copays, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits.

Some of the terms used in this document begin with capital letters, even though such-terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that they may present to providers whenever they receive services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document.

This document became effective on January 1, 2026.

PLAN INFORMATION

Plan Name	**NYC Members PPO plan**
Name And Address Of Employer	**Members** City of New York acting through the Mayor's Office of Labor Relations - Member Benefits Program 22 Cortlandt Street, 12th Floor New York, NY 10007
Name, Address, And Contact Information Of Plan Administrator	**Members** City of New York acting through the Mayor's Office of Labor Relations - Member Benefits Program 22 Cortlandt Street, 12th Floor New York, NY 10007 Refer to the New York City Health Benefits Summary Program Description located on the Office of Labor Relations (OLR) website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page for Your agency health benefits or payroll office contact information.
Named Fiduciary	**Members** **City of New York acting through the Mayor's Office of Labor Relations - Member Benefits Program**
Claims Appeal Fiduciary For Medical Claims	EmblemHealth | UnitedHealthcare
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. EmblemHealth | UnitedHealthcare provides administrative services such as claim payments for medical claims.
Funding Of The Plan	Employer and Member / pre-Medicare retiree Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by the City.
Collective Bargaining Provisions	Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Members and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

Compliance

It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and, in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to such benefits under the Plan.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Copays, Coinsurance, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Refer to the applicable section of the Schedule of Benefits that corresponds to the place of service to determine the appropriate coverage.

Benefits listed in this Schedule of Benefits are subject to all provisions of this Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Preferred:
Available in the downstate New York area (EmblemHealth Bridge network).

- Advantage Care Physicians New York (ACPNY)
- NYC Health + Hospitals (H+H)

Facility only:

- Memorial Sloan Kettering Cancer Center (MSK)
- Hospital for Special Surgery (HSS)

Participating Includes EmblemHealth Bridge network (downstate 13 counties), UnitedHealthcare national Choice Plus network and MAPFRE network in Puerto Rico.

Out-of-Network: Non-contracted providers You pay the difference between the plan allowance and the provider's fee.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:			
• Per Individual	$0	$0	$200
• Per Family	$0	$0	$500
Paid By Member, Unless Otherwise Stated Below:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Annual Coinsurance Out-Of-Pocket Maximum: • Per Individual	Not Applicable	$200	$2,000
Annual Copay Out-Of-Pocket Maximum: • Per Individual	Not Applicable	Not Applicable	$1,250
Annual Total Out-Of-Pocket Maximum Includes: ➢ **Annual Deductibles** ➢ **Annual Coinsurance Out-Of-Pocket Maximums** ➢ **Annual Copay Out-Of-Pocket Maximum** ➢ **Separate Deductibles** ➢ **Coinsurance That Do Not Apply To The Annual Coinsurance Out-Of-Pocket Maximums** ➢ **Copays That Do Not Apply To The Annual Copay Out-Of-Pocket Maximum** ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** • Per Individual • Per Family	$7,150 $14,300	$7,150 $14,300	Unlimited Unlimited
	Note: Once The Annual Total Out-Of-Pocket Maximum Is Reached, Member Cost Share Will Be Waived For The Remainder Of The Calendar Year.		

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Ambulance Transportation:			
Emergent Ground Ambulance:			
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Emergent Air Ambulance:			
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Non-Emergent Ground Ambulance:	Not Covered	Not Covered	Not Covered
Non-Emergent Air Ambulance:			
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Breastfeeding Support, Supplies, And Counseling:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Nursing Bras:			
• Maximum Benefit Per Calendar Year	3 Nursing Bras		
• Paid By Member	No Charge	No Charge	No Charge

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Durable Medical Equipment: ***Note: DME, Supplies Related To Enteral Feedings, Orthotics, Prosthetics, And Wigs Are Subject To The Same Deductible.***			
• Separate Deductible Per Calendar Year	$100 ***Note: Deductible Does Not Apply To Diabetic Equipment Including Insulin Pumps.***		
• Paid By Member	No Charge After Satisfaction Of Separate Deductible	No Charge After Satisfaction Of Separate Deductible	After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived)
Emergency Services / Treatment: **Urgent Care:**			
• Copay	$50 Per Visit	$50 Per Visit	$0
• Paid By Member	No Charge After Copay	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
H&H Urgent Care:			
• Copay	$25 Per Visit	Not Applicable	Not Applicable
• Paid By Member	No Charge After Copay	Not Applicable	Not Applicable
Urgent Care CityMD And ProHealth Urgent Care (Non-Preferred Urgent Care Providers):			
• Copay	Not Applicable	$100 Per Visit	Not Applicable
• Paid By Member	Not Applicable	No Charge After Copay	Not Applicable

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Walk-In Retail Health Clinics:			
• Copay	$0	$15 Per Visit	$0
• Paid By Member	No Charge	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Emergency Room Only:			
• Copay (Waived If Admitted As Inpatient Within 24 Hour(s))	$150 Per Visit	$150 Per Visit	$150 Per Visit (Emergency Room Copay Does Not Apply To The $1,250 Combined Annual Copay Out-Of-Pocket Maximum.)
• Paid By Member	No Charge After Copay	No Charge After Copay	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Emergency Physicians Only:			
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Non-Emergent Emergency Room / Emergency Physicians:	Not Covered	Not Covered	Not Covered

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			
• Maximum Days Per Calendar Year	90 Days		
Extended Care Services Only:			
• Copay	$0	$300 Per Admission Up To $750 Maximum Copay Per Calendar Year (Copay Combined For Extended Care Facility Benefits, Inpatient Hospital Services, And Inpatient And Residential Mental Health And Substance Use Disorder Benefits)	$500 Per Admission Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge After Copay	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Extended Care Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Gender Dysphoria: • Paid By Member ***Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.***	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Travel And Lodging:			Not Covered
• Maximum Benefit Per Calendar Year	$2,000		
• Paid By Member	No Charge	No Charge	
Home Health Care Benefits: • Copay	$0	$0	$50 Per Episode (Copay Per Episode Is Based On Prior Authorization Case, Extensions Of The Original Prior Authorization Do Not Incur Additional Copay. Copay Per Episode Does Not Apply To The $1,250 Combined Annual Copay Out-Of-Pocket Maximum.)
• Maximum Visits Per Calendar Year	200 Visits ***Note: Visit Limits Do Not Apply To The Diagnosis Of Autism.***		40 Visits ***Note: Visit Limits Do Not Apply To The Diagnosis Of Autism.***
• Paid By Member	No Charge	No Charge	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Coinsurance Does Not Apply To The $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum.)

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Qualified Dietician, Or Home Health Aide, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			
Hospice Care Benefits: **Hospice Services:** • Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Bereavement Counseling: • Maximum Visits Per Calendar Year	5 Visits		
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Hospital Services: **Outpatient Pre-Surgical Admission Testing Only:** • Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Pre-Surgical Admission Testing Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Note: Pre-Surgical Admission Testing Must Be Performed Within 21 Days Of Admission.			
Inpatient Services Only; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Copay	$0	$300 Per Admission Up To $750 Maximum Copay Per Calendar Year (Copay Combined For Extended Care Facility Benefits, Inpatient Hospital Services, And Inpatient And Residential Mental Health And Substance Use Disorder Benefits)	$500 Per Admission Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge After Copay	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Inpatient Physician Charges Only: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. ***Note: Emergency Admission At An Out-Of-Network Facility Will Pay In-Network At The Participating Level Of Benefits Until The Member Is Stabilized And Able To Be Transferred To An In-Network Facility.***
Outpatient Services / Outpatient Physician Charges: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Advanced Imaging Charges Only: • Copay • Paid By Member	$50 Per Visit No Charge After Copay	$100 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Advanced Imaging Physician Charges Only: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
H&H Advanced Imaging Charges:			
• Copay	$25 Per Visit	Not Applicable	Not Applicable
• Paid By Member	No Charge After Copay	Not Applicable	Not Applicable
Outpatient Lab And X-Ray And Diagnostic Testing Charges Only:			
• Copay	$0	$20 Per Visit	$0
• Paid By Member	No Charge	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Lab And X-Ray And Diagnostic Testing Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Surgery Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	20% Coinsurance Up To $200 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Surgeon Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Pain Management:			Not Covered
• Paid By Member	No Charge	No Charge	
Outpatient Cardiac Rehabilitation Services Only:			
• Copay	$0	$30 Per Visit	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge After Copay	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Cardiac Rehabilitation Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Blood Charges Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	20% Coinsurance Up To $200 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Blood Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Chemotherapy Charges Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	20% Coinsurance Up To $200 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Chemotherapy Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Outpatient Kidney Dialysis:			
• Maximum Visits Per Calendar Year	No Visit Maximum	No Visit Maximum	10 Visits
Outpatient Kidney Dialysis Charges Only:			
• Paid By Member	No Charge	20% Coinsurance Up To $200 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Out-Of-Network Coinsurance Applies To Participating $200 Annual Coinsurance Out-Of-Pocket Maximum.)
Outpatient Kidney Dialysis Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Hyperbaric Oxygen Therapy Charges Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	20% Coinsurance Up To $200 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Out-Of-Network Coinsurance Applies To Participating $200 Annual Coinsurance Out-Of-Pocket Maximum.)
Outpatient Hyperbaric Oxygen Therapy Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim:			
• Copay	$0	$30 Per Visit	$0
• Paid By Member	No Charge	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim: • Copay - Primary Care Physician • Copay - Specialist • Paid By Member	$0 $0 No Charge	$15 Per Visit $30 Per Visit No Charge After Copay ***Note: Multiple Copays Can Apply Per Visit.***	$0 $0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Infant Formula: • Paid By Member	20% Coinsurance	20% Coinsurance (Coinsurance Does Not Apply To The $200 Combined Annual Coinsurance Out-Of-Pocket Maximum.)	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Coinsurance Does Not Apply To The $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum.)
	Note: $100 Separate Deductible For DME, Supplies Related To Enteral Feedings, Orthotics, Prosthetics, And Wigs Does Not Apply To Infant Formula.		
H&H Infant Formula: • Paid By Member ***Note: Infant Formula Must Be Administered Through A Tube.***	No Charge	Not Applicable	Not Applicable
Infertility Treatment: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
In Vitro Fertilization:			
• Maximum Benefit Per Lifetime	3 Cycles		
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			
Your Provider Must Obtain Authorization From WIN For Fertility Treatment. To Request Authorization, Your Provider Can: ➢ **Call 833-439-1515; or** ➢ **Submit Online At https://www.winfertilityprovider.com/**			
Learning Disability: To Age 3			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
From Age 3	Not Covered	Not Covered	Not Covered
Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			
Manipulations:			
• Copay	$0	$15 Per Visit	$0
• Paid By Member	No Charge	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Maternity: **Routine Prenatal Services:** • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Prenatal Genetic Testing:			
• Maximum Visits Per Pregnancy	1 Visit		
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Non-Routine Prenatal Services, Delivery, Postnatal Care, And Postnatal Office Visits: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Home Health Care Visit:			
• Maximum Visits Per Delivery	1 Visit ***Note: Maximum Visit Per Delivery Does Not Apply To Home Health Care Benefits Maximum.***		
• Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Mental Health And Substance Use Disorder Benefits: **Inpatient Services Only:**			
• Copay	$0	$300 Per Admission Up To $750 Maximum Copay Per Calendar Year (Copay Combined For Extended Care Facility Benefits, Inpatient Hospital Services, And Inpatient And Residential Mental Health And Substance Use Disorder Benefits)	$500 Per Admission Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge After Copay	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Inpatient Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Residential Services Only:			
• Copay	$0	$300 Per Admission Up To $750 Maximum Copay Per Calendar Year (Copay Combined For Extended Care Facility Benefits, Inpatient Hospital Services, And Inpatient And Residential Mental Health And Substance Use Disorder Benefits)	$500 Per Admission Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge After Copay	20% Coinsurance Up To $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum Per Calendar Year You Pay The Difference Between The Plan Allowance And The Provider's Fee
Residential Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. ***Note: Emergency Admission At An Out-Of-Network Facility Will Pay In-Network At The Participating Level Of Benefits Until The Member Is Stabilized And Able To Be Transferred To An In-Network Facility.***

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Outpatient Or Partial Hospitalization Services And Physician Charges: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Office Visit: • Copay • Paid By Member	$0 No Charge	$15 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Opioid Treatment Program: • Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Mobile Crisis Intervention: • Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Morbid Obesity Treatment: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Nutritional Supplement: ***Note: Nutritional Supplement Must Be Administered Through A Tube.*** **Enteral Feedings:**			
• Paid By Member	20% Coinsurance	20% Coinsurance (Coinsurance Does Not Apply To The $200 Combined Annual Coinsurance Out-Of-Pocket Maximum.)	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee (Coinsurance Does Not Apply To The $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum.)
	Note: $100 Separate Deductible For DME, Supplies Related To Enteral Feedings, Orthotics, Prosthetics, And Wigs Does Not Apply To Enteral Feedings.		
H&H Enteral Feedings: • Paid By Member	No Charge	Not Applicable	Not Applicable
Supplies Related To Enteral Feedings: ***Note: Supplies Related To Enteral Feedings, DME, Orthotics, Prosthetics, And Wigs Are Subject To The Same Deductible.***			
• Separate Deductible Per Calendar Year	$100		
• Paid By Member	No Charge After Satisfaction Of Separate Deductible	No Charge After Satisfaction Of Separate Deductible	After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived)

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Orthotic Appliances: ***Note: Orthotics, DME, Supplies Related To Enteral Feedings, Prosthetics, And Wigs Are Subject To The Same Deductible.***			
• Separate Deductible Per Calendar Year	$100		
• Paid By Member	No Charge After Satisfaction Of Separate Deductible	No Charge After Satisfaction Of Separate Deductible	After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived)
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider**			

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**			
Primary Care Physician Visit: • Copay • Paid By Member	$0 No Charge	$15 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Specialist Visit: • Copay • Paid By Member	$0 No Charge	$30 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
		The Copays Will Not Apply To: ➢ **Services Billed By Radiologist Or Pathologist**	
Physician Office Services: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
	Note: Multiple Copays Can Apply Per Visit.		
Allergy Injections And Sublingual Drops: • Copay - Primary Care Physician	$0	$15 Per Visit	$0
• Copay - Specialist • Paid By Member	$0 No Charge	$30 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Allergy Testing: • Copay • Paid By Member	$0 No Charge	$20 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Diagnostic X-Ray And Laboratory Tests And Diagnostic Testing: • Copay • Paid By Member	$0 No Charge	$20 Per Visit No Charge After Copay (Copay Combined For Allergy Testing, And Diagnostic X-Ray And Laboratory Tests And Diagnostic Testing)	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Office Advanced Imaging: • Copay • Paid By Member	$50 Per Visit No Charge After Copay	$100 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
	Note: ➢ ***Copays Apply To Freestanding Radiology Centers (FSR) And Independent Labs.*** ➢ ***Copays Do Not Apply To Reading Of Labs, X-Rays, Or Advanced Imaging Done By An Ologist.***		
H&H Advanced Imaging Charges: • Copay • Paid By Member	$25 Per Visit No Charge After Copay	Not Applicable Not Applicable	Not Applicable Not Applicable

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Office Pain Management:			Not Covered
• Paid By Member	No Charge	No Charge	
Office Cardiac Rehabilitation:			
• Copay	$0	$30 Per Visit	$0
• Paid By Member	No Charge	No Charge After Copay	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			
Preventive / Routine Physical Exams At Appropriate Ages:			
To Age 19			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
From Age 19			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Immunizations:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Foreign Travel Immunizations:	Not Covered	Not Covered	Not Covered

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Mammograms And Breast Exams And 3D Mammograms For Preventive Screenings: From Age 35 To Age 40			
• Maximum Exams	1 Exam		
From Age 40			
• Maximum Exams Per Calendar Year	1 Exam		
Preventive / Routine Mammograms And Breast Exams And 3D Mammograms For Preventive Screenings Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Mammograms And Breast Exams And 3D Mammograms For Preventive Screenings Physician Charges Only:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Additional Screening And Diagnostic Imaging For The Detection Of Breast Cancer Including Diagnostic Mammograms, Breast Ultrasounds, And MRIs:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Pelvic Exams And Pap Tests:			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Cervical Cancer Screening:			
• Maximum Exams Per Calendar Year	1 Exam		
Cervical Cancer Screening Only:			
• Copay	$0	$0	$500 Per Visit Up To $1,250 Combined Annual Copay Out-Of-Pocket Maximum Per Calendar Year
• Paid By Member	No Charge	No Charge	20% Coinsurance You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Cervical Cancer Screening Physician Charges Only: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine PSA Test And Prostate Exams: From Age 40			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Member ***Note: Covered Under Age 40 For Personal History Of Prostate Cancer.***	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: From Age 45			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Preventive / Routine Hearing Exams: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling**			

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
***These Services May Also Apply To Men.**			
Note: If The Benefit Maximums Are Met, Or If The Benefit Is Outside Of The Allowable Age Range, Or If The Benefit Is Not Covered As Preventive / Routine, The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			
Preventive / Routine Care Benefits For Children Include:			
Preventive / Routine Physical Exams: To Age 19			
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
From Age 19			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Immunizations: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Foreign Travel Immunizations:	Not Covered	Not Covered	Not Covered
Preventive / Routine Screenings At Appropriate Ages: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Diagnostic Tests, Lab, And X-Rays: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Preventive / Routine Hearing Exams: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Note: If The Benefit Maximums Are Met, Or If The Benefit Is Outside Of The Allowable Age Range, Or If The Benefit Is Not Covered As Preventive / Routine, The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Private Duty Nursing: • Separate Deductible Per Calendar Year	(No Deductible)	(No Deductible)	$250
• Paid By Member	No Charge	No Charge	20% Coinsurance After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived) (Coinsurance Does Not Apply To The $2,000 Combined Annual Coinsurance Out-Of-Pocket Maximum.)
Prosthetics: ***Note: Prosthetics, DME, Supplies Related To Enteral Feedings, Orthotics, And Wigs Are Subject To The Same Deductible.***			
• Separate Deductible Per Calendar Year	$100		
• Paid By Member	No Charge After Satisfaction Of Separate Deductible	No Charge After Satisfaction Of Separate Deductible	After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived)
Sexual Assault Forensic Exams: • Paid By Member	No Charge	No Charge	You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Teladoc Health Services: **24/7 Care:** • Copay • Paid By Member ***Note: Multiple Copays Apply When Multiple Claims Are Billed On The Same Date Of Service.***	$10 Per Occurrence No Charge After Copay		Not Covered

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Telehealth: • Copay - Primary Care Physician • Copay - Specialist • Paid By Member	$0 $0 No Charge	$15 Per Visit $30 Per Visit No Charge After Copay	$0 $0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Temporomandibular Joint Disorder Benefits: • Paid By Member ***Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.***	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Therapy Services: • Copay • Paid By Member	$0 No Charge	$20 Per Visit No Charge After Copay	$0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Developmental Delays: To Age 3 • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
From Age 3	Not Covered	Not Covered	Not Covered

	PREFERRED	PARTICIPATING	OUT-OF-NETWORK
Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.			
Vision Care Benefits: • Copay - Primary Care Physician • Copay - Specialist • Paid By Member	$0 $0 No Charge	$15 Per Visit $30 Per Visit No Charge After Copay	$0 $0 After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: ***Note: Wigs, DME, Orthotics, Supplies Related To Enteral Feedings, And Prosthetics Are Subject To The Same Deductible.***			
• Separate Deductible Per Calendar Year	$100		
• Maximum Benefit Per Calendar Year	1		
• Paid By Member	No Charge After Satisfaction Of Separate Deductible	No Charge After Satisfaction Of Separate Deductible	After Satisfaction Of Separate Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee. (Annual Plan Deductible Waived)
All Other Covered Expenses: • Paid By Member	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

TRANSPLANT SCHEDULE OF BENEFITS

Transplant Services at Designated Transplant Facilities

Benefit Plan(s) 001

Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Member **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Member Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant. ***Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.***	No Charge $10,000 No Charge		
	PREFERRED	**PARTICIPATING**	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** • Paid By Member ***Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.***	No Charge	No Charge	After Satisfaction Of Plan Deductible, You Pay The Difference Between The Plan Allowance And The Provider's Fee.

BARIATRIC PROGRAM SCHEDULE OF BENEFITS Benefit Plan(s) 001			
	PREFERRED	**PARTICIPATING**	**OUT-OF-NETWORK**
Bariatric Program Services: • Paid By Member ***Note: The Member May Be Responsible For Copays, Coinsurance, Or Deductible, Depending On Where The Services Are Received.***	No Charge	No Charge	Not Applicable

OUT-OF-POCKET EXPENSES AND MAXIMUMS

COPAYS

A Copay is the amount that the Covered Person pays each time certain services are received. The Copay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not apply toward satisfaction of Deductibles. Copays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Copay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy out-of-network Copays and out-of-network Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, or Negotiated Rate.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Copays, or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that they paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by the New York City Health Benefits Program. The eligibility and enrollment procedures of the New York City Health Benefits Program include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the New York City Health Benefits Program may request documentation from You or Your Dependents in order to make determinations for continuing eligibility.

Please refer to the New York City Health Benefits Summary Program located at Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page, for the following:

- Member, pre-Medicare retiree, and Dependent Plan eligibility criteria and requirements
- Plan enrollment and HR or Benefits / Payroll Office contact information
- Effective Date of coverage for Members, pre-Medicare retirees, and Dependents
- Annual Fall Transfer Period
- Special enrollment provisions under the Health Insurance Portability and Accountability Act
- Termination / Reinstatement of Plan coverage
- COBRA Continuation of Coverage
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- Surprise Billing Protections

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much they will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose their own provider of medical care at their own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  EmblemHealth Bridge Program, UnitedHealthcare Choice Plus

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

In addition to services required to be covered as specified under the Protection from Balance Billing section of the New York City Health Benefits Summary Program Description (located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page), some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Emergent Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services provided by a Physician (excluding surgeons) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- If there is no In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 75-mile radius of the Covered Person's residence, the Covered Person may be eligible to receive In-Network Participating level of benefits for 12 months from an Out-of-Network provider. The Member must notify customer service before services are rendered to receive this benefit.

Provider Directory Information

Each covered Member, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Member should share this document with other covered individuals in their household. If a covered spouse or Dependent wants a separate provider list, they may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE FOR CURRENT AND NEW MEMBERS

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current claims administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Member's or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days after the Plan's effective date with the current claims administrator for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).
- Being an Inpatient in a Hospital on the Covered Person's Effective Date.
- Post-acute Injury or surgery within the past three months.
- Pregnancy care through delivery and any postpartum care directly related to delivery.
- Behavioral health (any previous treatment).

You or Your Dependent must call EmblemHealth | UnitedHealthcare within 60 days prior to Your Effective Date or within 60 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor Illnesses, and elective surgical procedures will not be covered by transitional level benefits.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

- Undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;

- Pregnant and being treated; or
- Terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the CARE section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions (Elective).**

3. **Allergy Testing and Treatment:** Testing and evaluations, including injections and sublingual drops, scratch and prick tests to determine the existence of an allergy, allergy treatment, including desensitization treatments, routine allergy injections, and serum.

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency Medically Necessary air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below.)

7. **Augmentation Communication Devices** and related instruction or therapy.

8. **Autism Spectrum Disorders (ASD) Treatment.**

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

9. **Autologous Blood Banking Services.**

10. **Biofeedback Services** for fecal and urinary incontinence only.

11. **Biomarker Precision Medical Testing** if Medically Necessary.

    The test is excluded if considered Experimental or Investigational.

12. **Blood, Blood Products, and Blood Derivatives** and services and equipment related to its administration.

13. **Blood Pressure Cuffs / Monitors.**

14. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

15. **Breast Reductions** if Medically Necessary.

16. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period. Breastfeeding supply coverage includes nursing bras.

17. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

18. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

19. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

20. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn is also covered as stated under nursery and newborn medical benefits.

21. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

22. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive mobile app subscription (e.g., Natural Cycles).
    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

23. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

24. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, including implants. Treatment must be completed within 12 months of the initial Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 5 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

25. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

26. **Diabetic Supplies.**

27. **Durable Medical Equipment (DME),** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits may be payable for subsequent repairs including batteries, or replacement only if required:
        - due to the growth or development of a Dependent Child;
        - because of a change in the Covered Person's physical condition; or
        - because of deterioration caused from normal wear and tear.

      The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse, misuse, loss, or theft, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

- Rental period for diabetic equipment including insulin pumps is capped at 13 months for rental-to-purchase items. Members may purchase prior to the 13-month period.
- Medical supplies and ostomy supplies follow the DME benefit.

28. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits. Refer to the Glossary of Terms for a definition of an Emergency Condition.

29. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

    - Room and board.
    - Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

30. **Eye Refractions** if related to a covered medical condition.

31. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

32. **Gender Dysphoria:** Benefits for the Medically Necessary treatment of Gender Dysphoria provided by or under the direction of a Physician. For the purpose of this benefit Gender Dysphoria is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Surgeries that alter physical appearance only and are not for the treatment of Gender Dysphoria are not covered by the Plan.

    This Plan provides an allowance for reasonable travel and lodging expenses, up to the maximum listed on the Medical Schedule of Benefits, if any, for a Covered Person and travel companion when the Covered Person must travel at least 75 miles from their address, as reflected in our records, to receive the covered health services from an available Network provider. Lodging expenses are further limited to $50 per night for the Covered Person, or $100 per night for the Covered Person with a travel companion.

    Please remember to save travel and lodging receipts to submit for reimbursement. Travel and lodging reimbursements that exceed IRS limits may be subject to IRS codes for taxable income. If You would like additional information regarding travel and lodging, You may contact us at the telephone number on Your ID card.

33. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

Genetic testing must also meet at least one of the following:

- The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
- Conventional diagnostic procedures are inconclusive.
- The patient has risk factors or a particular family history that indicates a genetic cause.
- The patient meets defined criteria that place them at high genetic risk for the condition.

34. **Hearing Services** include:

- Exams, tests, services, and supplies to diagnose and treat a medical condition.
- Implantable hearing devices, including semi-implantable hearing devices.

35. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

36. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Bereavement Counseling** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

37. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private and private room and board services:
  - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
  - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

38. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

39. **House Calls.**

40. **Hyperbaric Oxygen Therapy.**

41. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

42. **Infertility Treatment:** Diagnosis and treatment (surgical and medical) of Infertility.

For the definition of Infertility, please refer to the New York City Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Coverage includes Basic Infertility Services:

- Initial evaluation.
- Semen analysis.
- Laboratory evaluation.
- Evaluation of ovulatory function.
- Postcoital test.
- Endometrial biopsy.
- Pelvic ultrasound.
- Hysterosalpingogram.
- Sonohysterogram.
- Testis biopsy.
- Blood tests.
- Medically appropriate treatment of ovulatory dysfunction.

Covered Infertility Treatment includes genetic testing to diagnose infertility.

Additional tests may be covered if the tests are determined to be Medically Necessary. If the basic Infertility services do not result in increased fertility, then Comprehensive Infertility Services and Advanced Infertility Services will be covered.

- Comprehensive Infertility Services:
  - Ovulation induction and monitoring.
  - Pelvic ultrasound.
  - Artificial insemination.
  - Hysteroscopy.
  - Laparoscopy.
  - Laparotomy.

- Advanced Infertility Services and Standard Fertility Preservation Services: Refer to the New York City Health Benefits Summary Program Description, located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page, for covered services.

The Plan excludes:

- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers.
- Costs associated with an ovum or sperm donor, including the donor's medical expenses.
- Ovulation predictor kits.
- Reversal of tubal ligations.
- Reversal of vasectomies.
- Costs for and relating to surrogate motherhood.
- Cloning.
- Medical and surgical procedures that are Experimental or Investigational.

43. **Kidney Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

44. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

45. **Learning Disability:** Special education, remedial reading, school system testing and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability, except when such services are provided by a school.

46. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

47. **Marriage Counseling** that is part of a behavioral health treatment plan.

48. **Maternity Benefits** for Covered Persons: Maternity care, including Hospital, surgical, or medical care the same extent that coverage is provided for Illness or disease under the policy. This maternity care coverage, other than coverage for perinatal complications, must include:

    - Inpatient Hospital or Birthing Center room and board coverage for the mother and newborn for at least 48 hours after childbirth for any delivery other than a Cesarean section and for at least 96 hours after a Cesarean section.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Home births.
    - Midwives.
    - Prenatal genetic testing.
    - Home Health Care visit following a routine Inpatient delivery if the mother is discharged early from the Hospital.
    - Prenatal vitamins.

49. **Medical and/or Routine Services Provided in a Foreign Country,** except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

50. **Mental Health Treatment.** (Refer to the Behavioral Health Benefits section of this SPD.)

51. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Bariatric surgery, including, but not limited to:
  - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
  - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
  - Lap band (laparoscopic adjustable gastric banding).
  - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
- Physician-supervised weight loss programs at a medical facility.
- Charges for diagnostic services.
- Nutritional counseling by registered dieticians or other Qualified Providers.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

52. **Neuropsychological Exams for Dyslexia.**

53. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Member or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

Expenses for the covered newborn will be processed under the mother's benefits for 31 days. If the mother is not a covered Member, the newborn will be covered under the Member. If the covered newborn needs to stay in the Hospital longer, those charges will be processed under the newborn's benefits subject to the Deductible and other Plan provisions, including HIPAA Special Enrollment.

54. **Nutritional Counseling** for preventive services that are required under the United States Preventive Services Task Force and/or for the treatment of behavioral/mental health conditions.

55. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the enteral feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

56. **Occupational Therapy.** (See Therapy Services below.)

57. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Excision of exostosis of jaws and hard palate.

58. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

59. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include supports, trusses, elastic compression stockings, and braces.

60. **Oxygen and Its Administration.**

61. **Pain Management.**

62. **Panniculectomy** if determined by the Plan to be Medically Necessary.

63. **Pasteurized Donor Human Milk (PDHM)** (may include fortifiers if medically indicated) when ordered by a licensed medical practitioner for an infant who is medically / physically unable to receive maternal breast milk or whose mother cannot produce sufficient milk despite optimal lactation support. The infant must have a birth weight of <1,500 g or have a congenital / acquired condition, placing the infant at high risk of necrotizing enterocolitis.

64. **Pharmacological Medical Case Management** (medication management and lab charges).

65. **Physical Therapy.** (See Therapy Services below.)

66. **Physician Services** for covered benefits.

67. **Pre-Surgical Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

68. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

69. **Preventive / Routine Care** as listed under the Schedule of Benefits.

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
    - Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus;
  - Screening and counseling for interpersonal and domestic violence; and
  - Breast cancer genetic test counseling (BRCA) for women at high risk.

  Please visit the following links for additional information:

  https://www.healthcare.gov/preventive-care-benefits/
  https://www.healthcare.gov/preventive-care-children/
  https://www.healthcare.gov/preventive-care-women/

70. **Private Duty Nursing Services** when Outpatient care is required and Medically Necessary. Coverage does not include Inpatient private duty nursing services.

71. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

72. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
    - The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the NIH; and
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

73. **Radiation Therapy and Chemotherapy** when Medically Necessary.

74. **Radiology and Interpretation Charges.**

75. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery when such service is incidental to or follows a surgery resulting from trauma, infection, or diseases of the involved part, and reconstructive surgery because of a congenital disease or anomaly of a covered Child which has resulted in a functional defect.

76. **Respiratory Therapy.** (See Therapy Services below.)

77. **Scalp Cooling Systems** during the course of chemotherapy.

78. **Second Opinion (Cancer Diagnosis or Surgery)** if given by a board-certified Specialist in the medical field related to cancer diagnosis or the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

79. **Sexual Assault Forensic Exams.**

80. **Sexual Function:** Diagnostic services, non-surgical and surgical procedures in connection with treatment for impotence.

81. **Sleep Disorders** if Medically Necessary.

82. **Sleep Studies.**

83. **Speech Therapy.** (See Therapy Services below.)

84. **Sterilizations.**

85. **Substance Use Disorder Services.** (Refer to the Behavioral Health Benefits section of this SPD.)

86. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

87. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician. Consultations made by a Covered Person to a Physician.

88. **Telemedicine.** (Refer to the Teladoc Health Services section of this SPD for more details.)

89. **Temporomandibular Joint Disorder (TMJ) Services** include:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

The Plan excludes:

- Orthodontic services.
- Dental examinations even if provided for a TMJ diagnosis.
- Dental X-rays even if performed for a TMJ diagnosis.
- Treatment of TMJ by occlusal adjustment.

90. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) , audiologist (AUD), or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

The Plan allows coverage for medical charges and occupational, or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy when performed by a Qualified Provider. The Plan allows coverage for the treatment of disorders such as speech, language, voice, communication, and auditory processing. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident.

91. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.

92. **Transplant Services.** (Refer to the Transplant Benefits section of this SPD.)

93. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

94. **Vision Care Services.** (Refer to Vision Care section of this SPD.)

95. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

96. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

TELADOC HEALTH SERVICES

Note: Teladoc Health Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc Health may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc Health can be used for the following types of conditions:

- 24/7 Care general medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc Health website, via the call center, or via the Teladoc Health mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc Health does not guarantee that every consultation will result in a Prescription. Medications are prescribed at the Physician's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after their consultation to call Teladoc Health with any clarification questions. A member of the Teladoc Health clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation, they will be charged the Teladoc Health consultation fee.

Teladoc Health may not be used for:

- Drug Enforcement Agency (DEA) controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc Health.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, home health aide, or other Qualified Provider, if applicable.

Information regarding Private Duty Nursing can be found elsewhere in this SPD.

Prior authorization may be required before receiving services. Please refer to the CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the CARE section of this SPD for prior authorization requirements

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits, You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition / Procurement means the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

Note: While providers are responsible for obtaining all prior authorizations, it is the member's responsibility to confirm with their provider that all authorizations have been obtained before treatment.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition / Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition / Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to Covered Person who is a recipient)

If the Covered Person lives more than 75 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be taxable income under the Internal Revenue Code.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition / Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

VISION CARE BENEFITS

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Copay if applicable, Plan Participation amount, maximums, and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Negotiated Rate.

COVERED BENEFITS

- Vision therapy services (including orthoptics) or supplies. Bimodular treatment is covered.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices, whether or not prescribed by a Physician or optometrist.
- Correction of visual acuity or refractive errors.
- Aniseikonia.
- Eye exam.
- Refraction.
- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
  - Lenticular.
  - Progressive.
- Frames.
- Contacts.
- Contact lens fitting.
- Safety lenses and frames.
- Eye surgeries used to improve or correct eyesight for refractive disorders, including LASIK surgery, radial keratotomy, refractive keratoplasty, or similar surgery.

BEHAVIORAL HEALTH BENEFITS

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorder, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

SUBSTANCE USE DISORDER BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, Substance Use Disorders, or dual-diagnosis facility for the treatment of Substance Use Disorder. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes.).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent *American Psychiatric Association Diagnostic and Statistical Manual* (DSM) for the new diagnosis.

CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and at the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. In general, when the Covered Person receives services from a Network Provider or facility, the provider or facility is responsible for obtaining the Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Network Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service clinical approval is on file). If it is not a Network Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Notes: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible through the **nyceppo.com** portal, by phone, or by fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

The **Site of Service** (SOS) program considers anticipated places of service into Prior Authorization requirements for certain services and procedures. The SOS program recognizes that the total cost of care can be positively impacted when services are rendered in specific settings, based on the type of service that is being provided. The effort is to ensure access to Medically Necessary care while minimizing out-of-pocket costs for Covered Persons.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **EmblemHealth | UnitedHealthcare**

DEFINITIONS

The following terms are used for the purpose of the CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Network Providers are providers participating in the Emblem Health Network when inside the Emblem Health service area, or in the UnitedHealthcare Choice Plus Network when outside of the Emblem Health service area.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization at the number on the back of Your ID card or complete a Prior Authorization search at **nyceppo.com** **before** a Covered Person receives services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, Acute Inpatient Rehabilitation, Inpatient Behavioral Health (acute care) or Residential Treatment Facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500.
- Prosthetics over $1,000.
- Potentially cosmetic and reconstructive procedures.
- Advanced imaging.
- Radiology Site of Service - MRI and CT (applies to patients age 18+ only).
- Outpatient Surgery Site of Service (applies to patients age 18+ only).
- Chemotherapy services (all diagnosis) managed by Prime Therapeutics at Phone: 833-519-4548, Fax: 888-656-6671, TTY: 711 or gatewaypa.com.
- Non-Emergent air transportation.
- Pain management.
- Surgical treatment for Gender Dysphoria.
- Genetic and molecular testing.
- Implantable spinal cord and nerve stimulators.
- Sleep apnea treatment.
- Sleep studies (attended).
- Advanced radiation treatment.
- Cardiology procedures.
- Dialysis.

- Spinal surgeries.
- Joint procedures.
- Medical Specialty Drugs managed by Prime Therapeutics at Phone: 833-519-4548, Fax: 888-656-6671, TTY: 711 or gatewaypa.com.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- Other outpatient or office services requiring Prior Authorization.
- Unlisted codes over $5,000.
- Home Health Care.
- Private Duty Nursing.
- Infertility Treatment by WIN. Your provider must obtain authorization from WIN for fertility treatment. To request authorization, Your provider can call 833-439-1515 or submit online at https://www.winfertilityprovider.com/.
- Physical Therapy and Occupational Therapy after 25 visits combined.
- Speech Therapy after 25 visits.
- Cochlear Implant.
- Enteral Formula.

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount a Covered Person may be required to pay if an authorization has not been completed prior to receiving certain services or prior to admissions as defined in this section. A penalty of $250 per day, up to a maximum of $500, may be applied per Inpatient admission if a Covered Person receives services from Out-of-Network providers but does not obtain the required Prior Authorization.

Note: While providers are responsible for obtaining all prior authorizations, it is the member's responsibility to confirm with their provider that all authorizations have been obtained before treatment.

Note: Penalty does not apply to Mental Health or Substance Use Disorder admissions for patients under age 18 for the first 14 days of admission.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Medical Director Oversight. A CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case management. Opportunities are identified by using a system-integrated, automated and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review may be conducted upon request or at the Plan's discretion, and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

CARE PROVISIONS

Digital Capabilities

Covered Persons in CARE programs will have access to the CARE app, powered by Personify. This app provides additional support to You when working with a CARE nurse. The nurse assigns a CAREpath related to Your condition that You work through together. In addition, this app provides health and wellness tips and insight into Your health conditions.

CARE Cues

CARE Cues features a digital solution for clinical gaps in care, including care for behavioral health and Substance Use Disorder. The CARE Cues program is integrated into a Covered Person's **nyceppo.com** portal with notifications sent to the Covered Person's email that include next best action education and prompts to close the gap(s) in care.

There are over 150 digital gaps in care, including missed wellness / preventative opportunities, duplicative treatment, treatment disparities, condition management, immunizations, chronic condition drug interactions, and more. The email notifications will be offered to those Covered Persons with viable email addresses on file.

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers review available clinical information from utilization activity and other available resources to identify anticipated member needs. Collaboration with the member, caregiver, and provider is initiated to coordinate care in order to address gaps and barriers with the goal of reducing readmissions and/or complications. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and Substance Use Disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

Emerging CARE

Emerging CARE focuses on Covered Persons who are showing health behaviors that could lead to movement to a high-risk status. CARE Coordinators will reach out via mailed letter or telephone to Covered Persons to assist them with health management. Outreach may be due to, but not limited to, frequent Emergency room visits, discharge support, Medical Specialty Medications, denial and appeal support, pre-surgical counseling for elective surgeries, and behavioral health/Substance Use Disorder member and family support.

Enhanced Behavioral Health CARE

Enhanced Behavioral Health CARE is designed to provide extended assistance for Covered Persons who can benefit from deeper behavioral health or Substance Use Disorder support. Our team of behavioral health registered nurses, social workers, and pharmacists are here to help program participants close gaps in care and improve self-management of their condition(s).

Our CARE team will also connect with Covered Persons after related Emergency room visits, Inpatient stays, and specific Outpatient services to ensure members are equipped with the tools and resources they need to self-manage their condition(s). Covered Persons who have behavioral health conditions or Substance Use Disorders can also self-enroll through the **nyceppo.com** portal or by calling 844-598-7539.

Maternity CARE

Maternity CARE provides pre-pregnancy/pregnancy education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term Hospital stays for both mothers and babies. Program members are contacted by CARE nurses at least once each trimester and once postpartum. This program also offers an educational call and materials specifically to assist the participant's support person.

The pre-pregnancy support program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, face risks not only to their babies, but also to themselves while they are pregnant.

Members can self-enroll in the Maternity CARE program by calling our toll-free number or enrolling online at **nyceppo.com**. They are then contacted by CARE nurses who have extensive clinical backgrounds in obstetrics/gynecology.

Bariatric Program

The Bariatric Program is a surgical weight loss solution for those individuals who qualify clinically for bariatric surgery. Specialized Nurse Navigators provide support through all stages of the weight loss surgery process. The program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education in the selection of a bariatric surgery program, and post-surgery and lifestyle management..

Enrollment for bariatric surgery must be initiated through the Bariatric Program. Covered participants seeking coverage for bariatric surgery should notify the Bariatric Program as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) by calling 888-936-7246 to enroll in the program.

In addition to the requirements listed below, additional authorization requirements may apply. Refer to the Services Requiring Prior Authorization section of this SPD.

The Plan covers surgical treatment of Morbid Obesity. Refer to the Covered Medical Benefits section of this SPD.

Contact Your employer with any questions related to this coverage or service.

The patient must have at least one complicating comorbidity directly related to, or exacerbated by, morbid obesity.

The patient must be 18 years of age or older. For an adolescent between 12 and 17 years of age, the bariatric surgical procedures are proven to be Medically Necessary for treating obesity when all criteria are met and the individual has received an evaluation at, or is in consultation with, a multidisciplinary center focused on the surgical treatment of severe childhood obesity.

The patient must provide documentation of a motivated attempt of weight loss through a structured diet program prior to bariatric surgery, which includes Physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program.

Pre-surgical psychological evaluation will be performed to rule out major Mental Health Disorders that would contraindicate surgery and determine patient compliance with postoperative follow-up care and dietary guidelines.

A Member may have more than one surgery as long as all the “standard” criteria in this document is met for the second surgery to occur.

Gastric bypass (Roux en Y), lapband, gastric sleeve, and duodenal switch are all covered procedures.

Post-surgery excess skin removal is not covered unless Medically Necessary.

Dialysis Network Services (DNS)

Dialysis Network Services (DNS) provides access to a preferred provider dialysis network and support from a CARE Nurse Manager by collaborating with the Covered Person to delay the progression of the disease to renal failure.

The CARE End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at a DNS preferred provider, the Covered Person must contact CARE at 866-494-4502.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not, however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this Plan during a claim determination period will not exceed the maximum available benefit for each Covered Service. Also, coverage is limited to what the plan would have paid as the primary plan and up to the remaining balance owed by the Member.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below.

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Member: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

TRICARE

If an eligible Member is on active military duty, TRICARE is the only coverage available to that Member. Benefits are not coordinated with the Member's health insurance plan.

In all instances where an eligible Member is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

THIRD PARTY RECOVERY, SUBROGATION, AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, disease, or disability is caused, in whole or in part by, or results from the acts or omissions of, Plan Participants and/or their Dependents, beneficiaries, estates, heirs, guardians, personal representatives, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident and/or other funds are available, including, but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participants, their attorneys, and/or the legal guardians of minor or incapacitated individuals agree that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agree to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant agrees the Plan will have an equitable lien on any funds received by the Plan Participant and/or their attorney from any source and said funds will be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Participant settles, recovers, or is reimbursed by any Coverage, the Plan Participant agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant. If the Plan Participant fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action, or rights that may arise against any person, corporation, and/or entity and to any Coverage to which the Plan Participant is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name, or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- Worker's Compensation or another liability insurance company; or
- any other source, including, but not limited to, crime victim restitution funds; any medical, disability, or other benefit payments; and school insurance coverage,

the Plan Participant authorizes the Plan to pursue, sue, compromise, and/or settle any such claims in the Plan Participant's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan is entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make-whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant is fully compensated by their recovery from all sources. The Plan will have an equitable lien that supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights that interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant's recovery is less than the benefits paid, the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement will apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision does not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement will apply without regard to the location of the event that led to or caused the applicable sickness, Injury, disease, or disability.

EXCESS INSURANCE

If, at the time of Injury, sickness, disease, or disability, there is available, or potentially available, any Coverage (including, but not limited to, Coverage resulting from a judgment at law or settlements), the benefits under this Plan will apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits will be excess to:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's Compensation or another liability insurance company; or
- Any other source, including, but not limited to, crime victim restitution funds; any medical, disability, or other benefit payments; and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Plan Participant dies as a result of their Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights will still apply, and the entity pursuing said claim will honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant and all others that benefit from such payment.

OBLIGATIONS

It is the Plan Participant’s obligation, at all times, both prior to and after payment of medical benefits by the Plan:

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- To provide the Plan with pertinent information regarding the sickness, disease, disability, or Injury, including accident reports, settlement information, and any other requested additional information;
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment, or settlement received, the Plan Participant will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant’s cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Plan Participant and/or their attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan.

MINOR STATUS

In the event the Plan Participant is a minor, as that term is defined by applicable law, the minor's parents or court-appointed guardian must cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fails to take such action, the Plan will have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval will be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality will not affect the remaining sections of this provision and Plan. The section will be fully severable. The Plan will be construed and enforced as if such invalid or illegal sections had never been inserted into the Plan.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

3. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

4. **Acupuncture Treatment.**

5. **Adult Daycare.**

6. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

7. **Appointment Missed:** An appointment the Covered Person did not attend.

8. **Assistance With Activities of Daily Living.**

9. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

11. **Blood:** Blood donor expenses.

12. **Breast Pumps,** unless covered elsewhere in this SPD.

13. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

14. **Claims** received later than 180 days from the date of service (In-Network Preferred and In-Network Participating) or 18 months from the date of service (Out-of-Network). Corrected claims including late charges must be received within the timely filing limits.

15. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

16. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

17. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan.

18. **Custodial Care** as defined in the Glossary of Terms of this SPD.

19. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

20. **Dental Services,** unless covered elsewhere in this SPD.

21. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

22. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.

23. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

24. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

25. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, or the Negotiated Rate. This exclusion does not apply to payments that may be required under the No Surprises Act.

26. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

27. **Extended Care:** Any Extended Care Facility services that exceed the appropriate level of skill required for treatment as determined by the Plan.

28. **Family Planning:** Consultations for family planning.

29. **Felony Participation.** The Plan does not cover any Illness, treatment, or medical condition due to Your participation in a felony, riot, or insurrection. This exclusion does not apply to coverage for services involving Injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

30. **Financial Counseling.**

31. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

32. **Foot Care (Podiatry):** Routine foot care.

33. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

34. **Growth Hormones,** unless covered elsewhere in this SPD. The Member must contact the Pharmacy Benefit Manager for benefits.

35. **Hearing Services:**

    - Purchase or fitting of hearing aids unless covered elsewhere in this SPD.

36. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

37. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

38. **Infertility Treatment:**

- Surgical reversal of a sterilized state that was a result of a previous surgery.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

39. **Inpatient Admission for Diagnostic Studies.**

40. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

41. **Lamaze Classes** or other childbirth classes.

42. **Liposuction,** unless covered elsewhere in this SPD.

43. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

44. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

45. **Marriage Counseling,** unless covered elsewhere in this SPD.

46. **Massage Therapy.**

47. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

48. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

49. **Nocturnal Enuresis Alarm.**

50. **Non-Custom-Molded Shoe Inserts.**

51. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of their license.

52. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

53. **Nursery and Newborn Expenses** for a grandchild of a covered Member or spouse.

54. **Nutritional Counseling,** unless covered elsewhere in this SPD.

55. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

56. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

57. **Palliative Foot Care.**

58. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones, and guest trays.

59. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

60. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Drug Benefits section of this SPD for coverage.

61. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

62. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

63. **Respite Care.**

64. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

65. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

66. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

67. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

68. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

69. **Services Provided By a Close Relative,** unless covered elsewhere in this SPD. See the Glossary of Terms section of this SPD for a definition of Close Relative.

70. **Services Provided By a School.**

71. **Sex Therapy.**

72. **Sexual Function:** Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for impotence.

73. **Standby Surgeon Charges.**

74. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Right of Subrogation, Reimbursement, and Offset section. See the Right of Subrogation, Reimbursement, and Offset section for more information.

75. **Surrogate Parenting and Gestational Carrier Services:** Any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Member or covered spouse acting as a surrogate parent.

76. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

77. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

78. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

79. **Travel:** Travel costs, unless covered elsewhere in this SPD.

80. **Vision Care,** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

81. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

82. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

83. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

84. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

85. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

86. **Workers' Compensation:** Health care services for which other coverage is required by federal, state, or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation. This exclusion does not apply to employers that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.

87. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

88. **Xolair.**

The Plan does not limit a Covered Person's right to choose their own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the claims administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Member
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 180 days from the date of service (In-Network Preferred and In-Network Participating) or 18 months from the date of service (Out-of-Network). Corrected claims including late charges must be received within the timely filing limits. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When EmblemHealth | UnitedHealthcare receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, EmblemHealth | UnitedHealthcare will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Copay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate: On occasion, EmblemHealth | UnitedHealthcare will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Copay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Out-Of-Network Reimbursement

Reimbursement for Covered Expenses received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor; or
- 100 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
  - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Copays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

For services received from a non-network provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

EmblemHealth | UnitedHealthcare will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment ending or being reduced.
- Emergency and/or Urgent Care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to EmblemHealth | UnitedHealthcare for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Member, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Member or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or their Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at **nyceppo.com** to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
NYCE Post Service Appeals
P.O. Box 211381
Eagan, Minnesota 55121

Send Pre-Service Claim Medical appeals to:
UHC Appeals
PO Box 64
Huntingdon Valley, Pennsylvania 19006
Fax: 1-888-615-6584

This Plan Sponsor contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
EmblemHealth
Attention: Grievances And Appeals
P.O. Box 2844
New York, New York 10116-2844

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or their authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

EmblemHealth | UnitedHealthcare must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 2 business days after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 30 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;

  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if EmblemHealth | UnitedHealthcare or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor EmblemHealth | UnitedHealthcare nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC Appeals
PO Box 64
Huntingdon Valley, Pennsylvania 19006
Fax: 1-888-615-6584

Notice of the right to external review for Post-Service appeals should be sent to:

NYCE Post Service External Review
P.O. Box 8048
Wausau, Wisconsin 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Member's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by EmblemHealth | UnitedHealthcare and has no material affiliation or interest with EmblemHealth | UnitedHealthcare or Your employer. EmblemHealth | UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of EmblemHealth | UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by EmblemHealth | UnitedHealthcare and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to EmblemHealth | UnitedHealthcare or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and EmblemHealth | UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and EmblemHealth | UnitedHealthcare and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on their knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under their identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. They should answer all questions to the best of their knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If a Member is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), their employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Member has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

A Member may choose not to retain group health coverage during an FMLA leave. When the Member returns to work following the FMLA leave, the Member's coverage will usually be restored to the level the Member would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

For further information about FMLA, please refer to the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your Plan Administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Member benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

DEFINITIONS

The following definitions are not intended to limit the definitions of these terms as set out at 45 CFR Parts 160 to 164.

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include, but are not limited to:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means the City.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Note: Please contact EmblemHealth | Prime Therapeutics or Your Plan Administrator with any questions related to this coverage or service.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or not their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether or not election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

Base Benefit Coverage

The Plan covers diabetic equipment, supplies, if prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under applicable state law as described below:

1. Diabetic Equipment and Supplies.

   The Plan covers the following equipment and related supplies for the treatment of diabetes when prescribed by your Physician or other provider legally authorized to prescribe:

   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets

- Oral agents such as glucose tablets and gels
- Anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as determined by us as appropriate for the treatment of diabetes

2. Pre-natal vitamins with folic acid.

3. Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").

4. Prescription drugs for pre-exposure prophylaxis (PrEP).

5. Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter.

Equipment, supplies, devices and prescription drugs are covered only when obtained from participating pharmacies. Supplies are limited to a thirty (30)-day supply up to a maximum of a ninety (90)-day supply.

Optional Drug Rider Coverage

Covered Prescription Drugs.

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

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a provider authorized to prescribe and within the provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On our Formulary; and
- Dispensed by a licensed pharmacy.
- Not otherwise covered under a different program (ex. PICA or Base Benefit).

Refills.

The Plan covers Refills of Prescription Drugs only when dispensed at a retail, home delivery or Designated Pharmacy as ordered by an authorized provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, the Plan allows for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the *Prescription Schedule of Benefits* section of this SPD.

Benefit and Payment Information.

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

   You have a three (3) tier plan design, which means that lower out-of-pocket expenses applies for tier 1 drugs and higher out-of-pocket expenses applies to tier 2 and tier 3 drugs.

   For most Prescription Drugs, you pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at your or your provider's request and our Formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not covered and must be paid by you in addition to the lower tier Cost-Sharing. If your provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, you, your designee or your provider may request that the Plan approves coverage at the higher tier Cost-Sharing.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, home delivery or Designated Participating Pharmacy, you are responsible for paying the lower of:

   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.
     (Your Cost Sharing will never exceed the Usual and Customary charge of the Prescription Drug)

3. **Non-Participating Pharmacies.** The Plan will not pay for any prescription drugs that you purchase at a non-participating retail or home delivery pharmacy other than as described above.

4. **Designated Pharmacies**. If you require certain prescription drugs including, but not limited to specialty prescription drugs, we may direct you to a "Designated Pharmacy" with whom we have an arrangement to provide those prescription drugs.

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

   If you are directed to a Designated Pharmacy and you choose not to obtain your prescription drug from a Designated Pharmacy, you will not have coverage for that prescription drug.

5. **Designated Retail Pharmacy for Maintenance Drugs.** You may also fill your Prescription Order for maintenance drugs for up to a ninety (90)-day supply at a designated retail pharmacy, with the exception of contraceptive drugs, devices, or products which are available for a twelve (12)-month supply. You are responsible for paying the lower of: The applicable Cost-Sharing; or

   - The Prescription Drug cost for that Prescription Drug.
     (Your Cost-Sharing will never exceed the Usual and Customary charge of the Prescription Drug.)

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

- Asthma;
- Behavioral Health;
- Blood pressure;
- Contraceptives;
- Diabetes;
- High cholesterol;
- Other maintenance drugs.

6. **Smart 90 Program – Mandatory Rx Program.** If you are taking maintenance medications to treat an ongoing health condition your maintenance medications can be filled by Amazon or at preferred retail pharmacy or pharmacies designated by us. You will receive the home delivery Cost-Sharing under either option.

   Why Fill a 90-Day Supply?

   You make fewer visits to the pharmacy to refill your medication, and you may be able to save money by filling your prescriptions 90-days at a time with the home delivery discount whether you use Amazon or at your Plan's preferred retail pharmacy.

   Member Home Delivery Responsibility.

   You are responsible for paying the lower of:

   - The applicable Cost-Sharing; or
   - The Prescription Drug cost for that Prescription Drug.
     (Your Cost-Sharing will never exceed the Usual and Customary charge of the Prescription Drug.)

7. **When a Brand-Name Drug Becomes Available as a Generic Drug.** When a brand-name drug becomes available as a generic drug, the tier placement of the brand-name Prescription Drug may change. If this happens, you will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned or the brand-name drug will be removed from the Formulary, and you no longer have benefits for that particular brand-name drug. Please note, if you are taking a brand-name drug that is being excluded or placed on a higher tier due to a generic drug becoming available, you will receive thirty (30) days' advance written notice of the change before it is effective. You may request a formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the *External Appeal* section of this SPD.

8. **Formulary Exception Process.** If a Prescription Drug is not on our Formulary, you, your authorized representative or your prescribing Health Care Professional may request a formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. If coverage is denied under our standard or expedited formulary exception process, you are entitled to an external appeal as outlined in the *External Appeal* section of this SPD. Visit our website at www.emblemhealth.com to find out more about this process.

9. **Standard Review of a Formulary Exception.** We will make a decision and notify you or your authorized representative and the prescribing Health Care Professional by telephone no later than seventy-two (72) hours after receipt of your request. We will notify you in writing within three (3) business days of receipt of your request. If the request is approved, the Plan will cover the Prescription Drug while you are taking the Prescription Drug, including any Refills.

10. **Expedited Review of a Formulary Exception.** If you are suffering from a health condition that may seriously jeopardize your health, life or ability to regain maximum function or if you are undergoing a current course of treatment using a non-formulary Prescription Drug, you may request an expedited review of a formulary exception. The request should include a statement from your prescribing Health Care Professional that harm could reasonably come to you if the requested drug is not provided within the timeframes for the standard formulary exception process. We will make a decision and notify you or your authorized representative and the prescribing Health Care Professional by telephone no later than twenty-four (24) hours after receipt of your request. The Plan will notify you in writing within three (3) business days of receipt of your request. If the request is approved, the Plan will cover the Prescription Drug while you suffer from the health condition that may seriously jeopardize your health, life or ability to regain maximum function or for the duration of your current course of treatment using the non-formulary Prescription Drug.

11. **Supply Limits.** Except for contraceptive drugs, devices, or products, the Plan will pay for no more than a ninety (90)-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a thirty (30)-day supply. However, for maintenance drugs the Plan will pay for up to a ninety (90)-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a ninety (90)-day supply at a retail pharmacy.

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

    Benefits will be provided for Prescription Drugs dispensed by a home delivery order pharmacy in a quantity of up to a ninety (90)-day supply. You are responsible for one (1) Cost-sharing amount for a thirty (30)-day supply up to a maximum of three (3) Cost-sharing amounts for a ninety (90)-day supply.

    Some Prescription Drugs may be subject to quantity limits based on criteria that we developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing our website at www.emblemhealth.com or by calling 1-855-283-2150. If the request to cover an amount that exceeds the Plan quantity level is denied, you are entitled to an Appeal pursuant to *the Utilization Review* and *External Appeal* sections of this SPD.

12. **Initial Limited Supply of Prescription Opioid Drugs.** If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and you have a copayment, your copayment will be the same copayment that would apply to a thirty (30)-day supply of the Prescription Drug. If you receive an additional supply of the Prescription Drug within the same thirty (30)-day period in which you received the seven (7) day supply, you will not be responsible for an additional copayment for the remaining thirty (30)-day supply of that Prescription Drug.

13. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if your Prescription Drug or dose changes or if we contact you and you confirm that you have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a fifteen (15)-day supply of your Prescription Order for certain drugs filled at a pharmacy instead of the full Prescription Order. You initially pay half the thirty (30)-day Cost-Sharing. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Multiple Sclerosis, and Oncology. This program applies for the first sixty (60) days when you start a new Prescription Drug. This program will not apply upon you or your provider's request. You or your provider can opt out by visiting www.emblemhealth.com or by calling 1-855-283-2150.

14. **DAW (Dispense As Written).** Your doctor may write DAW ("Dispense As Written") on your prescription for a brand-name drug if the brand-name drug is considered Medically Necessary to best mange your condition. When your doctor writes DAW on a prescription, your pharmacist is not allowed to substitute the brand-name drug with its generic equivalent. If you select a brand name drug when a generic equivalent is available, you may be subject to additional cost sharing.

Medical Management - Base and Optional Rider.

This Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing provider may be asked to give more details before determination is be made that the Prescription Drug is medically necessary.

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

   Preauthorization is not required for covered medications to treat a substance use disorder, including opioid overdose reversal medications prescribed or dispensed to you. Preauthorization and utilization review is required to obtain certain Prescription Drugs, which include migraine medications, anti-nausea medications, anti-fungal agents, anti-inflammatory agents, appetite suppressants, asthma/COPD medications, smoking deterrents, eczema medications, vitamin A-based medications for treatment of cystic acne and other drugs and drug classes.

   If your prescription is for a drug that is subject to preauthorization, your physician should contact our Pharmacy Benefits Services Department (PBSD) or designee. PBSD staff and your physician will decide, based upon our clinical guidelines, whether the prescription is medically necessary for your treatment or condition. Our PBSD staff and your physician will also decide, based upon the guidelines, whether the quantity or duration of the prescription is medically appropriate. Our PBSD staff will then notify you and your physician of its decision(s).

   If the prescription request is approved, then the pharmacist will fill your prescription and the prescription will be covered. If the prescription request is not approved, then the prescription will not be covered. If the prescription request is approved, but at a reduced quantity or duration, then only the reduced quantity or duration of the drug will be covered.

   Our PBSD staff will make its decision(s) in the time periods and in accordance with the other requirements that apply to utilization review decisions. If you disagree with the PBSD staff's decision(s), you may file an appeal. (Please refer to the section entitled *Utilization Review* of this SPD for information about timeframes and how to file an appeal).

   The preauthorization list will be reviewed and updated from time to time. We reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not covered under the Plan. Your Participating Provider may check with us to find out which Prescription Drugs are covered.

2. **Step Therapy.** Step therapy is a process in which you may need to use one (1) or more types of Prescription Drugs before the Plan will cover another as medically necessary. A "step therapy protocol" means the policy protocol or program that establishes the sequence in which the Plan will approve Prescription Drugs for your medical condition. When establishing a step therapy protocol, we will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require preauthorization under the step therapy program are also included on the preauthorization drug list. If a step therapy protocol is applicable to your request for coverage of a Prescription Drug, you, your authorized representative, or your Health Care Professional can request a step therapy override determination as outlined in the *Utilization Review Claims and Appeals (Related to Medical Necessity)* section of this SPD.

Limitations/Terms of Coverage.

1. The Plan reserves the right to limit quantities, day supply, early refill access and/or duration of therapy for certain medications based on medical necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If we determine that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of participating pharmacies and prescribing providers may be limited. If this happens, you may be required to select a single participating pharmacy and a single provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single participating pharmacy. Benefits will be paid only if your Prescription Orders or Refills are written by the selected provider or a provider authorized by your selected provider. If you do not make a selection within thirty-one (31) days of the date you will be notified, and a single participating pharmacy and/or prescribing provider will be selected for you.

3. Compounded Prescription Drugs will be covered only when the primary ingredient is a covered legend prescription drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require preauthorization.

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

5. The Plan does not cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a physician's office are covered under the outpatient and professional services section of this SPD.

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

7. The Plan does not cover Prescription Drugs to replace those that may have been lost or stolen.

8. The Plan does not cover Prescription Drugs dispensed while in a hospital, nursing home, other institution, facility, or if you are a home care patient, except in those cases where the basis of payment by or on behalf of you to the hospital, nursing home, home health agency or home care services agency, or other institution, does not include services for drugs.

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

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

11. The Plan does not cover Prescription Drugs or supplies used for the purpose of weight gain or reduction, obesity, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.

General Conditions.

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

2. **Drug Utilization and Cost Management.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, you benefit by obtaining appropriate Prescription Drugs in a cost-effective manner.

Prescription Schedule of Benefits

Note: UnitedHealthcare (the claims administrator) does not administer the benefits or services described within this provision. Please contact EmblemHealth | Prime Therapeutics or Your employer with any questions related to this coverage or service.

	Participating Network Pharmacy	Out of Network	Limitations, Exceptions and Other Important Information
Base Benefit - ACA mandated and diabetic	Insulin: $0 Diabetic supply only: generic $5 brand $15 Opioid withdrawal medication: Tier 1: 20% coinsurance w/ $5 min charge Tier 2: 40% coinsurance w/ $25 min charge Tier 3: 50% coinsurance w/ $40 min charge	Not Covered	ACA prescription drugs covered at $0. Cost share for each prescription up to 30-day supply (up to 90-day supply for home delivery). Cost share will only apply to the total out-of-pocket maximum. Prescriptions will not be filled at retail after 2 fills. PICA Specialty prescription drugs not covered. Non-PICA specialty drugs must be dispensed by the specialty pharmacy. Rider coverage only available to those who have selected the optional prescription rider.
Optional drug rider generic drugs (Tier 1)	Retail: 20% coinsurance with min charge of $5 or actual cost, if less Home delivery: $12.50	Not Covered	
Optional drug rider Preferred Brand drugs (Tier 2)	Retail: 40% coinsurance with min charge of $25 or actual cost, if less Home delivery: $50	Not Covered	
Optional drug rider Nonpreferred Brand Drugs (Tier 3)	Retail: 50% coinsurance with min charge of $40 or actual cost, if less Home delivery: $75	Not Covered	

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Please refer to the New York City Health Benefits Summary Program Description on the OLR website located at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) – for definition, please refer to the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Close Relative means a member of the immediate family. Immediate family includes a husband or wife, Domestic Partner, birth or adoptive parent, Child, sibling, Domestic Partner's Child, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events. Please refer to the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Copay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Covered Person / Member / Subscriber means an eligible New York City employee, pre-Medicare retiree, or Dependent who is enrolled under this Plan. Please refer to the New York City Health Benefits Summary Program Description on the OLR website located at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – for definition, see the New York City Health Benefits Summary Program Description located on the OLR website at hhttps://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Domestic Partner / Domestic Partnership – for definition, see the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Durable Medical Equipment (DME) means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined by the Plan. Refer to the New York City Health Benefits Summary Program Description located on the OLR website located at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

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

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

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not a Member or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen. Refer to the New York City Health Benefits Summary Program Description located on the OLR website at https://www.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which they are on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, Substance Use Disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, Substance Use Disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling EmblemHealth | UnitedHealthcare at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means any disease or condition that falls under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopment disorders in the most current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on mental and behavioral disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered benefit.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body mass Index of 40 or more, or 35 or more if experiencing health conditions directly related to their weight, such as high blood pressure, diabetes, sleep apnea, etc.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which they practice, the services being provided are within their scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the **NYC Employees PPO plan**.

Plan Participation / Coinsurance means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means the City of New York.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, chiropractic, maternal-fetal medicine (MFM), or the treatment of mental health/Substance Use Disorders, or a nurse practitioner, nurse practitioner-pediatrics, nurse practitioner-gerontology, nurse practitioner-adult, or nurse practitioner-family. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which they are practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Copays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

- Non-network Emergency health services.
- Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Substance Use Disorder means any disease or condition that falls under the diagnostic categories as a mental or behavioral disorder due to psychoactive substance use listed in the most current edition of the International Classification of Diseases section on mental and behavioral disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on mental and behavioral disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a covered benefit.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That a Member is prevented from engaging in any job or occupation for wage or profit for which the Member is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for a Member or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Member.