CDPHP UNIVERSAL BENEFITS, INC.
500 Patroon Creek Boulevard
Albany, New York 12206-1057
(518) 641-3000

CDPHP UBI EPO PLAN CERTIFICATE

This Certificate and the attached Contract and any Riders attached thereto outline the prepaid health care program, to the extent hereinafter defined and limited, to all eligible enrolled Members.

This Certificate is issued by CDPHP Universal Benefits, Inc. under a Contract for health benefits. It covers all eligible enrolled Members, as hereinafter described and as defined by the Group's remitting (underwriting) rules. Coverage is conditioned upon the terms set forth in the attached Form, including the accompanying Schedule of Benefits, and any Riders attached to that Form.

This Certificate is issued to the person named on the CDPHP Universal Benefits, Inc. Identification Card. Coverage under this Certificate and the Contract begins on the Member Effective Date and it will continue unless it is terminated for any of the reasons hereinafter described.

The insurance evidenced by this Certificate meets the minimum standards for basic hospital and basic medical insurance as defined by the New York State Insurance Department. It does not provide major medical insurance.

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SECTION I - INTRODUCTION

CDPHP Universal Benefits, Inc., (hereinafter CDPHP UBI) hereby agrees with the Group to provide Coverage for the Health Services set forth herein to Members, subject to exclusions, limitations, conditions and other terms of the Contract.

The Contract is made in return for the Group's application and payment of the required premium on behalf of the Group's employees, Members, and their Dependents Covered by the Contract. The Group will arrange to collect any applicable Subscriber contributions for the premium directly from the Subscriber. The Group shall pay the total monthly premium due CDPHP UBI on behalf of those Subscribers and any enrolled Dependents on or before the first day of any month during which Coverage is to be provided to those Subscribers and their enrolled Dependents. The Contract shall take effect as specified on the Group Effective Date. It will be continued in force by the timely payment of the required premium charges when due. It shall be subject to termination as provided herein.

All Coverage under the Contract shall begin at 12:01 a.m., Eastern Standard Time on the day indicated on the first page of the Contract.

A Member Covered by the Contract may not assign any of the benefits of the Contract to any person, corporation, or association except as provided herein. Any attempt to make such an assignment shall be void and, at CDPHP UBI's option, may result in the termination of the Member's Coverage.

The Contract shall be deemed to be delivered in and governed by the laws of the State of New York.

The Contract shall be controlling in case of any dispute or question concerning Coverage, rules of eligibility, enrollment, and participation in CDPHP UBI set forth in the Certificate issued to Members, or any other sources of general information about this Coverage.

The Contract may not be modified, amended or changed in any manner whatsoever, except in writing, signed by the President of CDPHP UBI. No employee, agent or other person is authorized to interpret, amend, modify or otherwise change the Contract in such a manner as to expand or limit the scope of Coverage or the conditions of eligibility, enrollment or participation in CDPHP UBI unless in writing and signed by the President.

Services are Covered only when Medically Necessary.

SECTION II – DEFINITIONS

1. **Accidental Dental**: trauma to sound natural teeth caused by something other than a natural function including chewing and grinding of the teeth.
2. **Accidental Injury**: an unforeseen and unintended injury.
3. **Adoptive Child**: a child or infant in whose behalf a Member is actively engaged in adoption proceedings, but such proceedings have not yet been completed.
4. **Allowed Amount**: the maximum allowable benefits payable under this Contract. For non-facility Participating Practitioners and Providers, the Allowed Amount shall be established in accordance with the agreement whereby the provider has agreed to provide Health Care Services to CDPHP UBI Members. For a Hospital or other Participating Practitioner or Provider facility, the Allowed Amount shall be established by statute, regulation or the rate negotiated for the Participating Practitioners and Provider facility to provide Health Care Services to CDPHP UBI Members, and may differ from the provider's charge. For non-Participating Providers or Practitioners, the Allowed Amount shall be the Usual, Customary and Reasonable rate payable in the rating region, but in no event greater than the provider's actual charge.
5. **Application/Change Form**: the form completed by a potential Subscriber requesting Coverage from CDPHP UBI and listing all Dependents to be Covered on the date such Coverage takes effect, or by Members who wish to add or delete Dependents or terminate Coverage.
6. **Benefit Period**: the 12-month period indicated on the Group Contract title page.
7. **COBRA**: Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
8. **Calendar Year**: a twelve-month period beginning January 1 and ending December 31 of each year.
9. **Certificate**: the document issued to a Subscriber which sets forth the terms, conditions, and limitations of CDPHP UBI's Coverage. The Certificate shall include this Contract and a cover page entitled "Certificate."
10. **Claim Form**: the form provided by CDPHP UBI for incurred Eligible Expenses for treatment by non-Participating Providers as explained in Section VI of the Contract.
11. **Coinsurance**: a charge, in addition to the premium, which the Member is required to pay for certain Health Services provided under the Contract. It is expressed as a percentage of the Allowed Amount for Health Services. The Member is responsible for the payment of any Coinsurance charge directly to the provider at the time that Health Services are provided.
12. **Coinsurance Maximum**: the total amount of applicable Coinsurance to be satisfied, after which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. The Member is also responsible for all differences, if any, between the Allowed Amount and the non-Participating Provider's charge regardless of whether the Coinsurance Maximum has been met.
13. **Continuous Confinement**: consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days, successive confinements due to the same or related causes unless between such confinements a Covered person has been actively at work, if an employee, or engaged in normal activity if not an employee, for a period of 90 days. A confinement for an Accidental Injury shall not be combined with another confinement for an illness in determining continuous Hospital confinement.
14. **Contract**: the fully signed and executed agreement entered into between CDPHP UBI and the Group on behalf of eligible enrolled Members. The Contract shall include the Group Contract title page, this form, and any applicable Riders.
15. **Contract Month**: a period commencing on the first day of each calendar month and ending the last day of that month.
16. **Copayment**: a charge, in addition to the premium, which the Member is required to pay per visit for certain Health Services provided under the Contract. It is expressed as a fixed dollar amount payable each time a given Health Service is provided regardless of the number of times it is provided. The Member is responsible for the payment of any Copayment directly to the provider when Health

Services are provided.

17. **Coverage or Covered**: the Health Services paid for under the Contract.
18. **Deductible**: a payment, in addition to the premium, expressed in dollars, based on the Allowed Amount, which the Member must pay before CDPHP UBI will pay any benefits. Copayments and/or Coinsurance are not applied until any applicable Deductible has been met. Claims incurred within a Benefit Period will be applied toward the Deductible in the order in which they are submitted to CDPHP UBI, not in the order of the date(s) Health Care Services were rendered. Charges incurred during the last three months of a Benefit Period that are applied toward the Deductible for that Benefit Period will also be applied toward the Deductible in the next Benefit Period, provided there is no break in Coverage.
19. **Dependent**: a person other than the Subscriber meeting all relevant applicable eligibility requirements set forth in Section III.A.2. of the Contract, and for whom the monthly premium has been received by CDPHP UBI.
20. **Diagnosis**: an act or process of identifying or determining the nature of disease or injury through examination.
21. **Durable Medical Equipment or DME**: items which can withstand repeated use, are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the home.
22. **Elective Admission**: any admission scheduled more than 24 hours in advance of the admission.
23. **Eligible Expenses**: the fees for Health Services Covered under the Contract. Eligible Expenses only include fees for services actually provided to Members.
24. **Emergency**: a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.
25. **Family Coverage**: includes Coverage for Subscriber and any Dependents.
26. **Group**: the employer, association or other entity which contracts with CDPHP UBI to provide Health Services to Members.
27. **Group Benefit Plan(s):** health benefit plans such as HMO Coverage, health insurance, employer self-insurance or other Group health plan that covers a Subscriber or Dependent as part of the Group.
28. **Group Effective Date**: the date agreed to by the Group and CDPHP UBI upon which the Group is entitled to enroll Members to receive Health Services from CDPHP UBI.
29. **Health Services/Health Care Services**: Medically Necessary services to treat Accidental Injuries or sickness, or Medically Necessary preventive care. Health Services do not include services which are not actually provided to Members.
30. **Home Health Care**: a program of care provided by an agency engaged in providing Home Health Care services including, but not limited to skilled nursing services.
31. **Hospice Care**: the care and treatment of a Member who has been certified by his/her physician as having a life expectancy of six months or less and which is provided by a hospice organization certified under the New York Public Health Law or under a similar certificate process required by the state in which the hospice is located.
32. **Hospital**: an acute general care facility operated pursuant to law which: (a) is primarily engaged in providing diagnostic and/or therapeutic services for surgical or medical Diagnosis, treatment, and care of injured and sick persons by, or under the supervision of, a staff of physicians; (b) has 24-hour nursing services by registered professional nurses; and (c) is not (other than incidentally) a place for rest, custodial care or the aged; or a nursing home, convalescent home or similar institution.
33. **Identification or ID Card**: the card that CDPHP UBI issues to its Members showing that they are entitled to receive Health Services from providers under the terms of the Contract.

34. **Individual Coverage**: refers to Coverage for Subscriber only.
35. **Lifetime Maximum**: the total Allowed Amount for Covered Benefits that CDPHP UBI will pay per Member per Lifetime pursuant to the Group Contract.
36. **Medically Necessary**: those Health Services defined by CDPHP UBI's Medical Director, or his/her designee, that are necessary to treat and/or alleviate symptoms of an illness, disorder, or condition, are rendered at an appropriate level of intensity, can reasonably be expected to promote effective outcomes, are provided efficiently and facilitate quality of care. More specifically, this includes treatments needed to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life resulting in illness or infirmity, interfere with such person's ability for normal activity, or threaten a major handicap.
37. **Medicare**: the Health Insurance for Aged and Disabled Program established pursuant to Title XVIII of the Social Security Act, as it is in effect at the Group Effective Date of the Contract or as that act may be subsequently amended.
38. **Member**: a Subscriber and/or Dependent.
39. **Member Effective Date**: the date from which Members are entitled to receive Health Services from CDPHP UBI**.**
40. **Mental Health Conditions**: acute mental, nervous or emotional disorder which is susceptible to short-term treatment and poses a serious threat to the mental or physical well-being of a Member.
41. **Non-Covered Service(s):** the Health Services not Covered under the Contract.
42. **Non-Group Contract**: a Contract issued by CDPHP UBI directly to a Member, in accordance with the Conversion Privilege described by Section IX of the Contract, or for any other reason, which requires the Member to pay the premium directly to CDPHP UBI for that Contract.
43. **Open Enrollment Period**: a period during which subscribers in a health benefit program have an opportunity to select an alternate health plan being offered to them, or a period when uninsured employees and their Dependents, if any, may obtain Coverage without presenting evidence of insurability.
44. **Participating Practitioner(s):** any licensed practitioner who has agreed under contract to provide Health Services to Members.
45. **Participating Provider(s):** any Hospital, Skilled Nursing Facility, Home Health Agency, ambulance service, laboratory or other health care provider that has agreed under contract to provide Health Services to Members.
46. **Physical Therapy**: Medically Necessary therapy which can result in significant clinical improvement in a Member's condition, at CDPHP UBI's sole discretion.
47. **Rider(s):** an agreement purchased by the Group which amends the Contract to provide Members with Coverage for additional and/or reduced Health Services. All Riders which apply to the Contract are attached to the Contract on the Group Effective Date of Coverage.
48. **Routine Care or Routine Health Care Services**: preventive Health Services including, but not limited to, screenings, physical examinations, well-child care, immunizations and gynecological examinations which are rendered in the absence of a Diagnosis of injury or illness.
49. **Semi-Private Room**: a room with two or more beds in a Hospital, Skilled Nursing Facility or other health care facility.
50. **Short-Term Therapy**: therapy that is anticipated to achieve measurable and practical goals in 60-days or less.
51. **Skilled Nursing Facility**: a facility providing therapeutic services to inpatients requiring medical and skilled nursing care as defined under Section 2801 of the Public Health Law and which is qualified to participate as an extended care facility under Title XVIII of the Social Security Act.
52. **Subscriber**: any person, other than a Dependent, who meets all relevant applicable eligibility requirements under Section III.A.1. of the Contract, who applies and is accepted for Coverage from CDPHP UBI, and for whom the monthly premium has been received by CDPHP UBI.
53. **Surgical Procedures**: those medical procedures consisting of: (a) operating procedures for the Diagnosis and treatment of an illness or injury; (b) endoscopies; (c) correction of dislocations; (d)

treatment of fractures; and (e) any puncture or incision of tissue or skin requiring the use of surgical instruments, including any pre- and post-operative care usually rendered in connection with such operation or procedure.

54. **Totally Disabled**: a condition when, by reason of Accidental Injury or illness, a working Member is incapable of performing tasks of any employment. In the case of a non-working Member when, by reason of injury or illness, he/she is wholly unable to engage in the normal activities of a person of the same sex and age.
55. **Urgent Care Facility**: a licensed facility which provides medical assistance to treat minor and non-life-threatening Accidental Injuries, illnesses, disorders or conditions.

SECTION III - ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

A. Eligibility.

Individuals are accepted for enrollment when they meet the requirements outlined below:

1. Subscribers: To be eligible to enroll as a Subscriber, an individual must meet the eligibility requirements listed below and any other eligibility requirements as may be imposed by the Group and agreed to by CDPHP UBI:
   a. Be an actual member of the Group entitled on his/her behalf to participate in health care benefits through the Group;
   b. Completed the length of service to satisfy the Group's waiting period;
   c. Work a minimum number of hours per week as required by the Group and agreed to by CDPHP UBI, but which is in no case less than 20 hours per week, or are an eligible retiree according to the guidelines agreed upon by the Group and CDPHP UBI; and
   d. Be 18 years of age or older, unless eligible under COBRA or New York State continuation rules; and
   e. Receive payroll wages as evidenced by the Group's New York State payroll wage filing statement or have other written documentation of employment status acceptable to CDPHP UBI.

   Medicare eligible Members over 65 who are employees of a Group with less than 20 employees, or a retiree in a Group with more than 20 employees, must obtain Medicare Part A (Hospital) and Part B (medical). A copy of the Member's Medicare card must be provided to CDPHP UBI prior to enrollment.
2. Dependents: To be eligible to enroll as a Dependent, an individual must either be:
   a. Married to the Subscriber;
   b. An unmarried child of the Subscriber including any stepchild, legally adopted child or proposed Adoptive Child who is:
      i) Dependent upon the Subscriber for support and maintenance;
      ii) Less than 19 years of age; and
      iii) Not on active duty in the armed forces of any country;
   c. Adoptive non-infant children are considered Dependents upon the date CDPHP UBI receives notification and payment for additional premium, if any, provided that the following steps resulting in final adoption are completed:
      i) The child is physically in the household of the Member;
      ii) The Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of taking physical custody;
      iii) No notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and
      iv) Consent to the adoption has not been revoked.

      If CDPHP UBI is not notified of and/or does not receive payment of any additional applicable premium for an Adoptive Child on or before the 31st day from the date of birth or the date the child is physically in the household of the Member, then Coverage will not begin until the Group's next Open Enrollment Period;
   d. Newly-born infants adopted by the Member or Subscriber are Covered from the moment of birth when the following steps resulting in final adoption are completed:
      i) CDPHP UBI is notified of the infant's birth within 31 days of the date of birth;
      ii) The Subscriber takes physical custody of the adoptive infant upon release from the Hospital;

iii) The Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of birth;
iv) No notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and
v) Consent to the adoption has not been revoked.

Coverage of the initial Hospital stay for a newly-born infant adopted by the Member or Subscriber is not provided by CDPHP UBI if a natural parent has insurance or other coverage is available for the adoptive infant's care;

e. An unmarried child of the Subscriber including any stepchild, legally adopted child, or proposed Adoptive Child who is the age of 19 or over and is:
   i) Incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the New York Mental Hygiene Law, or physical handicap, and who became so incapable prior to age 19 for the purposes of this provision unless eligibility for Dependent status has been extended by a Rider, in which case the age limit of the Rider shall apply; and
   ii) Chiefly dependent upon the Subscriber for support and maintenance. The Subscriber may be requested by CDPHP UBI to provide evidence of the handicapping conditions claimed to be existing for the Dependent child;
f. New Dependents, because of marriage, birth of a child, or adoption of a child, may be enrolled during an eligibility period extending for a period of 31 days after the Dependents first become eligible for Coverage from CDPHP UBI. Newborn children of a Subscriber will be Covered as Dependents from date of birth. Such newborn children, however, are not considered enrolled until the Subscriber submits the appropriate Application/Change Form and CDPHP UBI receives payment of additional applicable premium, if any;
g. An unmarried child for whom the Subscriber has legal custody or legal guardianship, who:
   i.) Is dependent on the Subscriber for medical care;
   ii.) Is less than 19 years of age unless eligibility for Dependent status has been extended by a Rider in which case the age limit of the Rider shall apply; and
   iii.) Is not on active duty in the armed forces of any country.

   (This does not include Dependents referred to in Section III.A.2.b. above.)

3. Persons not entitled to Coverage include:
   a. Persons who are in the armed forces of any government other than for duty of 31 days or less.
   b. Any child born to or adopted by a Subscriber's Dependent child
   c. An ex-spouse of the Subscriber.
   d. Foster Children, unless otherwise eligible due to legal guardianship or legal custody as set forth in 2.g. above.
   e. Medicare eligible members over 65 years of age who are eligible for and do not enroll in Medicare Part A and Part B and are employed in a Group with less than 20 employees, or are a retiree of a Group with more than 20 employees.
4. CDPHP UBI reserves the right to examine a Group's records including payroll records and an individual's health, employment, or membership records in determining eligibility status for membership or under certain benefit exclusions (such as, but not limited to Workers' Compensation).
5. CDPHP UBI reserves the right to request and be furnished with such proof as may be needed to determine eligibility status of a Member.

B. Enrollment

1. Subscribers may join CDPHP UBI, only on the Group's anniversary date, upon meeting the eligibility requirements imposed by the Group and agreed to by CDPHP UBI, or during special Open Enrollment Periods agreed upon by both the Group and CDPHP UBI.
2. Newly hired employees may enroll upon meeting the eligibility requirements imposed by the Group and agreed to by CDPHP UBI. The Group agrees to give all employees or Members of the Group the CDPHP UBI Application/Change Form and descriptive literature as soon as they become eligible for Coverage. Such persons may apply for Coverage from CDPHP UBI within 31 days of the date they become eligible for Coverage. If such persons do not apply within 31 days of the date they become eligible, they must wait until the Group’s next Open Enrollment Period to become Covered.
3. Coverage will begin as follows:
    a. If the potential Subscriber files an Application/Change Form with CDPHP UBI before becoming eligible for Coverage, his/her Coverage starts on the date such person becomes eligible.
    b. If the potential Subscriber files an Application/Change Form with CDPHP UBI within 31 days after his/her date of eligibility, Coverage starts on the date of eligibility.
    c. If a Subscriber marries and files an Application/Change form with CDPHP UBI within 31 days after the marriage indicating that he/she wants Family Coverage, Coverage for such Dependents starts on the date of the marriage.
    d. If a Member gives birth to or adopts a child and has Family Coverage, Coverage for the child starts on the date the child is born or adopted, provided that the Member submits an Application/Change Form with CDPHP UBI within 31 days of the birth or adoption. If the Member does not have Family Coverage, Coverage for the child will still begin on the date of the birth or adoption if the Member submits an Application/Change Form requesting Family coverage to CDPHP UBI within 31 days of the birth or adoption.
4. Special Enrollment Periods.
    a. CDPHP UBI shall permit an employee who is eligible, but not enrolled, for Coverage under the terms of the Contract (or a Dependent of such an employee if the Dependent is eligible, but not enrolled, for Coverage under such terms) to enroll for Coverage under the terms of the Contract if each of the following conditions is met:
        i) The employee or Dependent was covered under a group health plan or had health insurance coverage at the time Coverage was previously offered to the employee or Dependent.
        ii) The employee’s or dependent’s coverage described in Section III.B.4.a.i. above
            a. Was under a COBRA continuation provision and the coverage under such provision was exhausted; or
            b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce or annulment, death of a spouse, termination of employment, termination of the other plan or contract, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
        iii) The employee requests such enrollment not later than 31 days after the date of exhaustion of coverage described in Section III.B.4.a.ii.a. or termination of Coverage or employer contribution described in Section III.B.4.a.ii.b.
    b. If a person becomes a Dependent of a Member (or has met any waiting period applicable to becoming a Member and is eligible to be enrolled but for failure to enroll during a previous enrollment period) through marriage, birth, or adoption or

placement for adoption, the person (or, if not otherwise enrolled, the individual) may be enrolled as a Dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a Dependent of the individual if such spouse is otherwise eligible for Coverage.

A Dependent special enrollment period under this Section III.B.4.b. shall be a period of not less than 31 days and shall begin on the later of:

i) The date Dependent Coverage is made available; or

ii) The date of the marriage, birth, or adoption or placement for adoption (as the case may be).

If an individual seeks to enroll a Dependent during the first 31 days of such a Dependent special enrollment period, the Coverage of the Dependent shall become effective:

i) In the case of marriage, not later than the first day of the first month beginning after the date the completed CDPHP UBI Application/Change Form is received;

ii) In the case of a Dependent's birth, as of the date of such birth; or

iii) In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

C. Termination of Coverage

A Member's Coverage shall automatically be terminated on the first of the following to apply:

1. Upon the Group's failure to pay the required premium to CDPHP UBI in accordance with the Contract title page.
2. The date that the Contract is terminated, or with respect to any specific Health Services Covered by the Contract, the date such Coverage terminates.
3. For Subscribers, the end of the month in which the Member ceases to be eligible as a Subscriber. For Dependent spouses in cases of divorce, the date of the divorce. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, unless the reason for ineligibility is that the Dependent child becomes married. In such cases, coverage will terminate as if the date of the Dependent's marriage.
4. The date on which the Subscriber ceases to meet eligibility requirements as defined by the Group or those requirements listed in Section III.A.1.
5. The end of the Contract Month during which the Group receives written notice from the Subscriber requesting termination of Coverage, or on such later date requested for such termination by the notice.
6. The end of the Contract Month during which the Subscriber is retired or pensioned, unless Coverage is specifically provided for retired or pensioned individuals by agreement between CDPHP UBI and the Group.
7. If a Subscriber has made a fraudulent misrepresentation of material fact in writing on his/her Application/Change Form, Coverage shall terminate immediately upon written notice of termination delivered by CDPHP UBI to the Group.
8. The date of entry into active military duty, except for temporary duty for 31 days or less. In the event of such termination, the Member may be entitled to supplementary conversion and continuation rights in addition to the conversion and continuation rights as described in Sections IX and X of this Contract. Nothing herein shall be interpreted to preclude the application of Insurance Law §4305(g) regarding supplementary conversion and continuation rights for members of a reserve component of the armed forces of the United States, including the National Guard, and their spouses and/or dependents.
9. If a Member fraudulently misrepresents a material fact in order to obtain Coverage for a non-Covered service, that Member's Coverage will terminate immediately upon receipt of a written notice of termination by CDPHP UBI to the Group.

If a Member’s Coverage is to be terminated for the reasons described in “7” through “9” above, CDPHP UBI shall notify the Member of the proposed termination of Coverage and the right to have the matter considered in accordance with CDPHP UBI’s Claims and Appeals Procedures described in Section XIII of the Contract prior to terminating Coverage. It shall not notify the Group of such termination until a final decision is issued in accordance with that grievance procedure.

If a Member’s Coverage is to be terminated for the reasons described above, the premium payment computation will be in accordance with the Contract title page.

SECTION IV – COVERED HEALTH CARE SERVICES

PAYMENT INFORMATION

A. **Deductible.** A payment, in addition to the premium, expressed in dollars, based on the Allowed Amount, which the Member must pay before CDPHP UBI will pay any benefits. Copayments and/or Coinsurance are not applied until any applicable Deductible has been met. Claims incurred within a Benefit Period will be applied toward the Deductible in the order in which they are submitted to CDPHP UBI, not in the order of the date(s) Health Care Services were rendered.
All Services (unless otherwise noted) are subject to a $**[0 – 6,000]** Deductible for Individual Coverage and a $**[0 – 15,000]** Deductible for Family Coverage (not to exceed **$[0 – 6,000]** for any one family Member per Benefit Period.) The Family Deductible is the combined total for the Subscriber and all Dependents.

B. **Coverage Maximum**

1. **Lifetime Maximum.** the total Allowed Amount for Covered Benefits that CDPHP UBI will pay per Member per Lifetime pursuant to the Group Contract
   a. For Covered Prosthetics Devices and DME pursuant to Section IV.P:
      The Lifetime Maximum is **$25,000.**
2. **Annual Maximum.** the total Allowed Amount for Covered Benefits that CDPHP UBI will pay per Member per Benefit Period pursuant to the Group Contract
   a For all Covered Services:
      The Annual Maximum is **Unlimited.**

Health Care Services from Providers.
Once the Deductible has been met, all Services will be subject to the Copayment listed below.
Only one visit Copayment will be required per provider per day. **Please see Section V.E. regarding requirements of the Managed Benefits Program.**

C. **Office Based Health Services. All services are subject to the Deductible, then [$10 - $50] Copayment.**
Service

1. Office and Home Visits, including periodic health examinations. **Subject to the Deductible, then $[10 - 35] Copayment.**
2. Diagnostic Services.:
   a. Radiology and Imaging Services. **Please see Section V.E. regarding requirements of the Managed Benefits Program.**
      i. X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs and CT Scans. **(Visit Copayment waived if services performed by preferred radiology network provider. A listing of preferred radiology providers will be provided upon request.)**
      ii. Other Surgical or Medical Diagnostic Radiology and Imaging Services
   b. Electroencephalograms.
   c. Electrocardiograms.
   d. Organ Scans.
   e. Laboratory Services.
      (Deductible and Copayment for the performance of laboratory services are

waived when provider utilizes CDPHP UBI's designated Participating laboratory Provider.)

f. Mammograms**. Covered in Full, not Subject to Deductible.**

g. Bone Mineral Density Measurements and Tests. **Subject to the Deductible, then $[10 - 35] Copayment.** Coverage is provided consistent with criteria under the federal Medicare program and the National Institutes of Health; provided that, to the extent consistent with such criteria, Members qualifying for Coverage shall, at a minimum, include individuals:

i. Previously diagnosed as having osteoporosis or a family history of osteoporosis; or

ii. With symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

iii. On a prescribed drug regimen posing a significant risk of osteoporosis; or

iv. With lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

v. With such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

h. Cervical Cytology Screenings. **Covered in Full, Not Subject to Deductible.**

3. Well child visits from birth up to the Member's 19th birthday. **Covered in Full, not subject to the Deductible.**

Recommended visits at:

a. 2 weeks; 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months.

b. Ages 2 to 19: One visit per Benefit Period.

c. Any other well child visits as recommended by the American Academy of Pediatrics.

d. Immunizations as recommended by the Advisory Committee on Immunization Practices.

Well child visits shall include: a medical history, physical examination, developmental assessment, anticipatory guidance, necessary and appropriate immunizations, and laboratory tests ordered at the time of the visit.

4. Annual physical for adults (over age 19) per Benefit Period directly related to the performance of the Routine physical exam.

a. Non-gynecological Routine physical exam once per Benefit Period

Covered in Full, Not Subject to the Deductible.

b. Gynecological Routine physical exam once per Benefit Period Age limitation in Section IV.C.4. does not apply to routine gynecological exams.

Covered in Full, Not Subject to the Deductible.

5. Medical Consultation Services.

6. Voluntary Family Planning.

7. Casts and Dressings.

8. Obstetrical Services. **Deductible then Covered in Full.**

a. Including, but not limited to, prenatal care, delivery and post-partum care. Coverage is also provided for the services of a duly licensed midwife. To be considered as In-Network, the midwife must have a written practice agreement with a Participating Provider. Payment for the Health Care Services Covered under this section for care and treatment during pregnancy shall be made in not less than two payments, at reasonable intervals and for services rendered, for prenatal care and a separate

payment for the delivery and post-partum care provided.

b. Upon submission of a receipt to CDPHP UBI as proof of payment, Members are eligible for reimbursement of 50% of the cost of childbirth classes up to a maximum of $30. Reimbursement is limited to one class per pregnancy.

9. Immunizations (see also Section VII).

   Covered in Full, Not Subject to the Deductible.

10. Allergy Tests.
11. Allergy Injections. **Deductible, then Covered in Full.**
12. Health Education and Nutritional Counseling.
13. Vision screenings done during a physical examination.
14. Hearing Examinations ordered by a physician.
15. Dental Services for the treatment of Accidental dental Injuries to sound natural teeth or dental treatment necessary due to congenital disease or anomaly. Coverage ends when the Member's Coverage under this Contract is terminated, even if the plan of treatment has not yet been completed.
16. Surgical Procedures when performed in the office.
17. Chiropractic Services provided by a doctor of chiropractic licensed pursuant to Article 132 of the Education Law, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
18. Standard diagnostic testing for prostatic cancer, including, but not limited to, digital rectal examinations and prostate-specific antigen tests.

    Covered in Full, not Subject to the Deductible.

19. Medication management rendered by a psychiatrist. See Exclusions Section VII.
20. Neuropsychological testing related to a medical Diagnosis and rendered by a practitioner. See Exclusions Section VII.

D. Practitioners' Services when billed separately by the provider, not by the facility, when the Member is either in the Hospital, in a Skilled Nursing Facility or at a facility as an Outpatient. All Services are subject to the Deductible then Covered in Full.

Service

1. Surgical Procedures. **Please see Section V.E. regarding requirements of the Managed Benefits Program and Section VII Exclusions.**
2. Assistant Surgeon. A provider who assists another provider during the course of the operation, when the surgical procedure requires assistance.
3. General and Local Anesthesia Services.
4. Radiotherapy Treatment.
5. In-facility consultations and visits.
6. Surgical Pathology.
7. Obstetrical Services.
8. Initial Newborn Care.
9. Diagnostic Test Result Interpretation Services.

E. Inpatient Hospital Services. Please see Section V.E. regarding requirements of the Managed

Benefits Program. The following services are subject to the Deductible then **$[0 – 1,000]** **C**opayment, whenever they are provided on an inpatient basis and billed by a Hospital. The following **C**opayments will be imposed per Continuous Confinement:
Individual Coverage: The Subscriber Covered under this plan is responsible for the applicable Copayment per Continuous Confinement. Inpatient Copayments are limited to two (2) per Benefit Period after which hospitalization will be Covered in full.
Family Coverage: The Subscriber and each Dependent must meet the applicable Copayment per Continuous Confinement. Inpatient Copayments are limited to three (3) per Benefit Period after which hospitalization will be Covered in full.
Service

1. Semi-Private Room.
2. Use of Operating, Recovery and Delivery Rooms.
3 Anesthetic Materials.
4. Laboratory Services.
5. Dressings and Casts.
6. Newborn Nursery Care. Inpatient Hospital care for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section.

Subject to the Deductible, then Covered in Full.

7. Diagnostic Radiology and Imaging Services.
8. Intravenous Injections and Infusion Therapy.
9. Electroencephalograms.
10. Electrocardiograms.
11. Oxygen.
12. Short-term Physical Therapy.
13. Intensive/Cardiac Care.
14. Central Supply Items.
15. Chemotherapy and Radiation Therapy.
16. Organ Scans.
17. Blood and blood products, but only when there is a charge by the facility.
18. Maternity care Coverage, including parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments, for Member and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and at least 96 hours following a caesarean section. The Member shall have the option to be discharged earlier than the 48 or 96 hours. In such case, one Home Health Care visit, which may by requested at any time within 48 hours of the time of delivery (96 hours in the case of caesarean section), shall be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother's request, whichever is later. Any such Home Health Care visit shall not be subject to Deductibles, Coinsurance, or Copayments.
19. Inpatient Hospital Coverage for such period as is determined by the attending physician in consultation with the Member to be medically appropriate after a Member has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy Covered by the Contract.
20. Drugs, medications, biologicals and vaccines used in the Hospital.

F. Outpatient Hospital Services. Please see Section V.E. regarding requirements of the Managed Benefits Program. The following Services are subject to the Deductible then $[15 – 100]

Copayment. After any applicable Deductible is met, Only one Visit Copayment will be required per Participating Provider and/or facility per day for the procedures listed below.
Service

1. Use of Operating and Recovery Rooms.
2. Anesthetic Materials.
3. Laboratory Services. **Deductible and Visit Copayment are waived when the Hospital is an approved drawing and/or laboratory site of CDPHP UBI's designated Participating laboratory Provider.**
4. Casts and Dressings
5. Diagnostic Radiology and Imaging Services.
    a. X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs and CT Scans. **Copayment is waived if services are performed by a preferred radiology network provider. A listing of preferred radiology providers will be provided upon request.**
    b. Other Surgical or Medical Diagnostic Radiology and Imaging Services.
6. Intravenous Injections.
7. Electroencephalograms.
8. Electrocardiograms.
9. Oxygen.
10. Short-term Physical Therapy subject to the terms of Section IV.Q. below.
11. Central Supply Items.
12. Chemotherapy and Radiation Therapy.
13. Organ Scans.
14. Preadmission Testing.
15. Drugs, medications, biologicals and vaccines used in the Hospital.
16. Blood and blood products, but only when there is a charge by the facility.

G. Emergency Services
Service

1. Emergency Department Services. **Subject to the Deductible, then $[50 – 100] Copayment. [**Copayment; Coinsurance] is waived only if the Member is admitted to the Hospital for observation or as an inpatient for the same Accidental Injury or illness within 24 hours.
2. Professional Ambulance Services. **Subject to the Deductible then $[50 – 100] Copayment.**
    a. Pre-Hospital Emergency medical services, including prompt evaluation and treatment of an Emergency condition and/or non-airborne transportation to a Hospital. Services must be provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law. Evaluation and treatment services must be for an Emergency condition as defined in Section II of this Contract. Coverage for non-airborne Emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: 1) placing the health of the person afflicted with such a condition in serious jeopardy; 2) serious impairment to such person's bodily functions; 3) serious dysfunction of any bodily organ or part of such person; and/or 4) serious disfigurement of such person.
    b. Airborne ambulance Services. Must be Medically Necessary and must be required as a result of an Emergency.
    c. Medically Necessary inter-facility transportation. **Subject to the Deductible then**

Covered in Full.

3. Urgent Care Facility Services. **Subject to the Deductible then $[20 – 45] Copayment. Non-Participating Urgent Care Facility Services within CDPHP UBI's service area are Not Covered.**

H. Freestanding Laboratory, Radiology/Imaging, and Ambulatory Surgery Facility Services. Please see Section V.E. regarding requirements of the Managed Benefits Program.

Service

1. All services provided by freestanding laboratory and radiology/imaging facilities. **Subject to the Deductible, then Covered in Full for all Facility Charges.**
2. All services provided by freestanding ambulatory surgery facilities. **Subject to the Deductible then $[15 – 100] Copayment.**

I. Chemical Abuse and Dependency Treatment Services.

Service

1. Outpatient Services. — Up to 60 visits per Calendar Year for Diagnosis and treatment of chemical abuse and dependency. Up to 20 of the 60 visits may be used for family therapy related to chemical abuse and dependency. **$[10 – 35] Copayment.**

   Outpatient chemical abuse services are not subject to the Deductible.
2. Inpatient Services. **Please see Section V.E. regarding requirements of the Managed Benefits Program.**
   i. Up to 7 days per Benefit Period for Medically Necessary inpatient detoxification for chemical abuse and dependency, including all facility, diagnostic and physicians' charges.
   ii. Up to 30 days per Benefit Period for inpatient rehabilitation services for the Diagnosis and treatment of chemical abuse and/or dependency in a Hospital-based or freestanding chemical dependency facility. Treatment must be provided by trained professional personnel and may include individual or group counseling, activity therapy and diagnostic evaluations to determine the nature and extent of the illness. **Subject to $[0 – 1,000] Copayment, Not subject to the Deductible.**
3. Limitations.
   a. Services must be provided in: Participating Provider facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services; and, in other states, to those accredited by the J.C.A.H.O. as alcoholism or substance abuse treatment programs.
   b. The Member must contact CDPHP UBI's designated chemical abuse and dependency treatment organization prior to receiving services.
   c. Persons whose prime Diagnosis is alcohol abuse or alcoholism may be treated only in a facility certified to treat such Diagnosis.
   d. Persons whose prime Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnosis.
   e. Care must be as a result of chemical abuse and dependence.
4. Treatment of associated health conditions will be Covered under basic Health Care Services of the Contract. Please see Sections IV.C., D. and E.

J. Acute Mental Health Services.

Service

1. Inpatient Services.—Up to 30 days per Benefit Period for treatment of acute Mental Health Conditions including all facility, diagnostic and physicians' charges. **Please see Section V.E. regarding requirements of the Managed Benefits Program. Subject to[$[0 – 1,000] Copayment, Not Subject to the Deductible.**
2. Outpatient Services.—The Member must contact CDPHP UBI's designated managed behavioral health care organization prior to receiving Covered Health Services from a psychologist, psychiatrist, subject to the Copayment in Section IV.C.) or social worker. Up to a maximum of 20 visits per Benefit Period whether individual or group therapy for evaluation and treatment of acute Mental Health conditions. **Visits 1-20 subject to $ 30 Copayment, Not Subject to the Deductible.**

K. Skilled Nursing Facility Services. Please see Section V.E. regarding requirements of the Managed Benefits Program.

Service

1. Up to 45 days per Benefit Period in a Semi-Private Room when ordered by a Member's physician after a Hospital stay for the same Accidental Injury or illness. Central supply items, drugs, medications, biologicals, and vaccines are Covered when provided by a Skilled Nursing Facility. **Subject to the Deductible then $[0 – 1,000] Copayment. Copayment is waived when admission to the Skilled Nursing Facility occurs within three (3) days of discharge from the Hospital and as an alternative to hospitalization.**

L. Home Health Care Services. Please see Section V.E. regarding requirements of the Managed Benefits Program.

Service

1. When ordered by a physician and approved in writing by CDPHP UBI's Medical Director or his/her designee as an alternative to hospitalization or treatment in a Skilled Nursing facility (as defined in 42 USC § 1395 et. seq.). The Covered services include: 1) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; 2) part-time or intermittent home health aide services which consist primarily of caring for the patient as an adjunct to Skilled Nursing services; 3) physical, occupational or speech therapy if provided by the home health service or agency; 4) medical supplies, drugs, and medications prescribed by a physician; 5) laboratory services by or on behalf of the home health agency; and 6) home infusion therapy. Home Health Care Services are Covered to the extent such items would have been Covered or provided if the Member were hospitalized or confined in a Skilled Nursing Facility. A care plan must be established in writing and approved by the physician and CDPHP UBI's Medical Director or his/her designee. CDPHP UBI's Medical Director or his/her designee has the right to determine if Home Health Care is the most cost-effective approach to care. This determination can be made at any time during an episode of care. The medical necessity of Home Health Care Services is determined on a case-by-case basis. **Subject to the Deductible then Covered in Full. Deductible for Home Health Care Services not to exceed $50 per member, per Benefit Period.**

M. Services by Non-Participating Providers.

Service

1. Subject to Section V.A., non-Participating Providers can provide Medically Necessary Covered Health Care Services. CDPHP UBI must approve such services in advance and in writing, except in Emergency situations. **Non-Participating Practitioners and Provider Services are subject to the Deductible, if any, Copayment and/or Coinsurance according to Section IV of this Contract.**

N. Second Opinions. Subject to the Deductible, then $[10 – 50] Copayment.
Service

1. Second surgical opinions.
2. Second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. Such Coverage shall include a second medical opinion from a non-Participating Provider specialist, including, but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, at no additional cost to the Member beyond what the Member would have paid for services from an appropriate Participating Provider specialist. Services are subject to prior written approval by CDPHP UBI's Medical Director or his/her designee.

O. Prosthetic and Orthotic Devices, Oxygen and Durable Medical Equipment. Please see Section V.E. regarding requirements of the Managed Benefits Program for information about any applicable maximum benefit limitations. Subject to 50% Coinsurance. Not Subject to the Deductible.
Service

1. Durable Medical Equipment (DME).

   CDPHP UBI will provide Coverage for rental, purchase, repair and/or replacement of DME (as defined in Section II of this Contract), subject to the following:

   a. The equipment has been ordered by a practitioner.
   b. Prior authorization by CDPHP UBI's Medical Director or his/her designee is required when the cost of the item being purchased exceeds $500. All rented items require prior authorization. **Please see Section V.E. regarding requirements of the Managed Benefits Program.**
   c. The equipment is provided by a Participating Provider vendor.
   d. Medically necessary repair, adjustment or replacement of Covered equipment is also Covered. CDPHP UBI reserves the right to determine whether replacement or repair is more appropriate.
   e. Coverage is provided for standard equipment only. Coverage for equipment with non-standard features is provided on a case-by-case basis, after review of medical necessity. If features or items deemed not Medically Necessary are included when the equipment is dispensed, CDPHP UBI will provide Coverage for only those items or features deemed Medically Necessary. All requests for potentially non-Medically Necessary features or items will be subject to CDPHP UBI's Utilization Review process, including all avenues of appeals (see Section XIII).
   f. CDPHP UBI reserves the right to determine whether rental or purchase is more appropriate.
   g. Supplies associated with DME are Covered when included in the rental fee or purchase price.
   h. Refer to Section VII for exceptions to Covered benefits.

2. Prosthetic Devices.

   Prosthetic Devices are removable and not permanently implanted devices which replace all or part of a body organ, or replace all or part of a permanently inoperative, absent or malfunctioning body part, including but not limited to, artificial limbs, eyes and post-

mastectomy breast prostheses. CDPHP UBI will provide Coverage for the purchase of prosthetic devices, subject to the following:

a. The device has been ordered by a practitioner.

b. Prior authorization by CDPHP UBI's Medical Director or his/her designee is required when the cost of the device exceeds $500. Prior authorization requirement does not apply to services listed in section 2.g. below. **Please see Section V.E. regarding requirements of the Managed Benefits Program.**

c. The device is provided by a Participating Provider vendor.

d. Medically necessary repair, adjustment or replacement of Covered equipment is also Covered. CDPHP UBI reserves the right to determine whether replacement or repair is more appropriate.

e. Coverage is provided for standard devices only. Coverage for devices with non-standard features is provided on a case-by-case basis, after review of medical necessity.

f. Supplies associated with prosthetic devices are Covered when included in the purchase price.

g. CDPHP UBI provides benefits for the purchase of one Medically Necessary cranial prosthesis, wig or toupee per lifetime per Member for replacement of hair lost as a result if injury, disease or treatment of a disease. Coverage is limited to a maximum amount of $400 per prosthesis, wig or toupee. The limitation is applied to the balance remaining after the Member's payment of the applicable Coinsurance as set forth in this Section. **Prior authorization requirement described in Section IV.O.2.b. does not apply to covered prosthesis, wigs or toupees.**

h. Refer to Section VII for exceptions to Covered benefits.

3. Orthotic Devices.

Orthotic devices are rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. CDPHP UBI will provide Coverage for the purchase of orthotic devices subject to the same criteria as set forth in paragraph 2.a. through g. above. There is no Coverage for orthotic shoe inserts (see Section VII).

4. Oxygen.

Medically Necessary oxygen is Covered, subject to the same criteria as set forth in paragraph 1.a. and 1.c through g. above. Oxygen is not subject to the prior authorization requirement set forth in 1.b. above.

P. Physical and Occupational Therapy Services.
Service

1. Includes Short-Term Therapy which can result in significant clinical improvement in a Member's condition. Coverage is limited to one course of 30 visits each for physical and occupational therapy per Benefit Period. (see Section VII) **Subject to the Deductible then $[10 – 50] Copayment.**

Q. Speech Therapy Services. Please see Section V.E. regarding requirements of the Managed Benefits Program.
Service

1. Includes Short-Term Therapy which can result in significant clinical improvement in a Member's condition. Coverage is limited to one course of 20 visits per Benefit Period. (See

Section VII.). **Subject to the Deductible then $[10 – 50] Copayment.**

R. Acute Short-Term Inpatient Rehabilitation Services. Please see Section V.E. regarding requirements of the Managed Benefits Program.

Service

1. Inpatient treatment in a rehabilitation unit or facility which can result in a significant clinical improvement in a Member's condition. Must be prior approved by CDPHP UBI's Medical Director or his/her designee after a Hospital stay for the same injury or illness. Admission must be within one day of a Hospital discharge and is limited to a maximum stay of 60 days for each specific Diagnosis and related conditions for a continuous 12-month period at the discretion of CDPHP UBI's Medical Director or his/her designee. **Subject to the Deductible then $[0 – 1,000] Copayment.**

S. Hospice Care. Subject to the Deductible then Covered in Full.

Service

1. Inpatient Services.—Care in a hospice or in a Hospital.
2. Outpatient Services.—Home Health Care and outpatient services provided by a hospice including drugs and medical supplies.
3. Family Visits.—Five visits for bereavement counseling, either before or after the terminally ill Member's death.
4. Limitations. — A total of 210 days as an inpatient and outpatient will be Covered. Total days of hospice are computed from the first day on which any hospice care is provided.

T. Diabetic Services. All Diabetic Services listed in section IV.T. are subject to a $[10;15] Copayment, not subject to the Deductible.

Service

1. Medically Necessary diabetic supplies and equipment, when recommended by a provider.
   a. Prior authorization by CDPHP UBI's Medical Director or his/her designee is required for Medically Necessary Durable Medical Equipment when the cost of the item being purchased exceeds $500. All rented items require prior authorization. **Please see Section V.E. regarding requirements of the Managed Benefits Program.** This equipment includes items such as: injection aids, insulin pumps and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors (including non-invasive, subcutaneous or implantable monitors) and blood glucose monitors for the visually impaired**.**
   b. Up to a 30-day supply of insulin and oral agents for controlling blood sugar, test strips for glucose monitors and visual reading and urine tests strips, syringes, lancets, insulin pump supplies and cartridges for the visually impaired.

      CDPHP UBI-approved diabetic drugs for chronic conditions are available by mail order. A 31 to 60-day supply will be dispensed subject to a two-month Copayment. A 61 to 90-day supply will be subject to a $[25; 37.50] Copayment. Contact the Member Services Department at (518) 641-3140 or 1-877-269-2134 for instructions on using the approved mail order program.
2. Medically Necessary self-management education and education relating to diet for persons diagnosed with diabetes provided by the physician or his/her staff, as part of an office visit for diabetes Diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician.
3. Routine eye examinations once every 12 months for Members that have a Diagnosis of

Diabetes. See also Section V.D.

U. Organ Transplant Services. Please see Section V.E. regarding requirements of the Managed Benefits Program. Services must be performed at a center in CDPHP UBI's designated specialty network. **Subject to the Deductible then $[0 – 1,000] Copayment unless otherwise noted.**

Service

1. Covered services include all Medically Necessary Hospital care at a transplant center and all Medically Necessary medical, surgical and other care otherwise Covered under this Contract.
2. Organ donation. CDPHP UBI will cover the expense for donor hospitalization and services directly related to the donation of an organ used in a Covered organ transplant (see Section VII).
3. Bone Marrow Searches.

   When the National Marrow Donor Program or the International Bone Marrow Transplant Registry or an equivalent registry or bank is utilized by a transplant center, CDPHP UBI will provide Coverage for confirmatory typings for up to 10 individual potential donors. The Member's family may be included in these 10 allowed typings. This coverage will be provided once per bone marrow transplant. **Subject to the Deductible then $[10 – 35] Copayment.**

V. Outpatient Dialysis Services.

Service

If a Member has chronic kidney failure and needs hemodialysis or peritoneal dialysis, benefits are available for these services on an ambulatory or home basis as follows:

1. In a Hospital-based or freestanding facility, dialysis treatment on a walk-in basis will be Covered if the facility and its programs are approved by the appropriate governmental authorities. **Subject to the Deductible then $[10 – 35] Copayment per visit in Facility.**
2. For home treatment, benefits will be provided for the reasonable rental cost of equipment, as determined by CDPHP UBI, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by the Member's physician. However, Covered benefits do not include any furniture, electrical or other fixtures, plumbing or professional assistance needed to perform the dialysis treatments at home. **Subject to the Deductible then $[10 – 35] Copayment per month in home.**
3. For these home and facility-based benefits to be Covered, the treatments must be provided, supervised or arranged by the Member's physician.

W. Laboratory Services.

Service

1. CDPHP UBI will provide Coverage for laboratory services when ordered by a physician, and received through a laboratory. **Subject to the Deductible then Covered in Full. Deductible for the performance of laboratory services is waived when services performed by approved drawing and/or laboratory site of CDPHP UBI's designated Participating laboratory Provider.]**
2. CDPHP UBI will also provide Coverage for laboratory services performed in conjunction with inpatient, outpatient, preadmission testing, ambulatory surgery and Emergency room services. See Sections IV.E., F., G. and H. for Copayment, Coinsurance and/or Deductible information for these service sites.

X. Breast Reconstruction Surgery.

Service

Coverage for breast reconstruction surgery after a mastectomy for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications of mastectomy, including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate.

Please refer to these Contract Sections regarding Copayment, Deductible and/or Coinsurance for each of the following sites of service: for physicians' office, see Section IV.C.; for inpatient Hospital, see Sections IV.D. and IV.E.; for outpatient Hospital, see Sections IV.D. and IV.F.; for ambulatory surgery facility, see Sections IV.D. and IV.H; for Prosthetic Devices, see Section IV.O.

Y. Access to End of Life Care.

Service

1. Coverage for acute Health Care Services at an acute-care facility licensed pursuant to Article 28 of the Public Health Law specializing in the treatment of terminally ill patients when the Member's attending physician, in consultation with the medical director of the facility, determines that the Member's care would appropriately be provided by such a facility. The Member must have a Diagnosis of advanced cancer with no hope of reversal of the primary disease and must be certified by his/her attending physician as having fewer than 60 days to live. If CDPHP UBI disagrees with the provision or continuation of such Coverage, CDPHP UBI will initiate the expedited external review process as described in Section XIII.G. of this Contract. CDPHP UBI will continue to provide Coverage for services provided by the facility until such review decision(s) is (are) rendered. **Subject to the Deductible then Covered in Full.**

Z. Infertility Services

Service

1. Hospital care, and surgical and medical care for the Diagnosis and treatment of otherwise Covered correctable medical conditions resulting in infertility including:
    a. Hospital care, surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility;
    b. Diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments Covered in Section Z.1.a above. Such Covered procedures and tests include, but are not limited to hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound. Artificial insemination procedures are also Covered.
2. Limitations.
    a. For the purposes of this Section IV.Z, the determination of "infertility"; the identification of non-Covered experimental procedures and treatments for the diagnosis and treatment of infertility; the identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility and the determination of appropriate medical candidates by the treating physician shall all be defined in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine.
    b. See Section VII for exceptions to Covered benefits.

c. Coverage for fertility drug treatment is only provided under a Prescription Drug Rider. Such Coverage is subject to the terms, conditions, limitations and exclusions of any such Rider.

d. Members must be at least 21 years of age but no more than 44 years old to be Covered under this Section IV.Z., for diagnostic and treatment procedures, used in the diagnosis and treatment of infertility including Prescription Drugs that may be Covered under any applicable Rider.

Please refer to these Contract Sections regarding Copayment, Deductible and/or Coinsurance for each of the following sites of service: for physicians' office, see Section IV.C.; for inpatient Hospital, see Sections IV.D. and IV.E.; for outpatient Hospital, see Sections IV.D. and IV.F.; for ambulatory surgery facility, see Sections IV.D. and IV.H.

SECTION V - LIMITATIONS OF COVERAGE

A. Services by non-Participating Practitioners and Providers

In the event that Covered Health Services cannot be provided by a Participating Provider or Practitioner, such services are available from a non-Participating Provider or Practitioner. Such Health Services must be authorized in advance and approved in writing by CDPHP UBI's Medical Director or his/her designee prior to the services being rendered. The services provided will be subject to the limitations and exclusions of the Contract. Health Services rendered by non-Participating Practitioners or Providers without prior written approval by CDPHP UBI's Medical Director or his/her designee will not be Covered, except for necessary Emergency care as described in Section V.B.

B. Emergency Department Health Services

Emergency department Health Services are Covered in the event of an Emergency (as defined in Section II). Members are responsible for the Emergency Copayment for Emergency department Health Services, even if authorized by a Participating Practitioner or Provider, unless they are admitted to the Hospital for observation or as an inpatient within 24 hours of the Emergency Health Services for the same illness or injury. CDPHP UBI must be notified within 48 hours after Emergency Health Services are initially provided by a non-Participating Provider, or as soon thereafter as is reasonably possible. Full details of the Emergency Health Services provided shall be made available to CDPHP UBI at its request. If the Member is hospitalized at a non-Participating Provider Hospital he/she shall be transferred to a Participating Provider Hospital, upon request of CDPHP UBI's Medical Director or his/her designee, as soon as it is medically appropriate in the opinion of the attending physician. Emergency department Health Services are not subject to prior approval.

C. Hospital, Skilled Nursing Facility and Home Health Care Services.

1. A Member must notify CDPHP UBI to arrange and authorize care if, on the Member Effective Date of the Contract, he/she:
   a. Was admitted to a Hospital under another plan and is currently an inpatient or admitted to that Hospital; or
   b. Is scheduled to be admitted to a Hospital, Skilled Nursing Facility or other health care facility; or
   c. Is receiving Home Health Care.

D. Review of Hospital Stay, Skilled Nursing Facility Stay, Home Health Care, and Inpatient Rehabilitation Unit or Facility Services.

If CDPHP UBI has notified the Member that the Member's continued stay or services are no longer Medically Necessary, and the Member elects to remain hospitalized and/or continue to receive such services, then the Member will be responsible for payment of all charges for the continued stay and/or services. CDPHP UBI will notify the Member and the Member's physician at least one day prior to the date that benefits for the continued stay and/or services will cease.

E. Managed Benefits for All Health Services

Please see also Section XIII for additional information. All requests for review of determinations of medical necessity are subject to the requirements of and timeframes set forth in Section XIV of this Contract.

Members are not subject to the requirements of this Section V.E. when they are admitted for Emergency Care or for delivery of a baby.

Except for admissions for Emergency care or for delivery of a baby, the Member must comply with CDPHP UBI's managed benefits program as set forth herein in order to receive

the maximum benefits for all Health Services available under this Contract. Failure to do so will result in the Member being responsible for an additional payment of 50 percent of the Allowed Amount up to a maximum of $500 for each service otherwise payable, in addition to the applicable Copayment, Deductible and/or Coinsurance.

CDPHP UBI's managed benefits program works with the Member and/or the Member's physician to ensure that the Member receives medically appropriate Health Services at an appropriate level of medical care. CDPHP UBI's managed benefits program consists of review of all Hospital admissions, ongoing review of hospitalization and discharge planning, individual case management and precertification for certain services including Skilled Nursing Facility care, Home Health Care, inpatient rehabilitation unit or facility services, prosthetic devices and Durable Medical Equipment exceeding $500, diabetic Durable Medical Equipment exceeding $500, outpatient cardiac rehabilitation Health Services beyond 36 sessions, outpatient speech therapy Health Services beyond one visit, Inpatient Mental Health Services and Inpatient Chemical Abuse and Dependency Treatment Services. The member will be notified of additional services which may require compliance with the managed benefits program in the future. Except in the case of an Emergency, all inpatient Hospital services must be precertified.

1. Pre-Admission Certification of Hospital Inpatient Care.

    The Member or the Member's physician must notify CDPHP UBI's Utilization Management Department when the Member's physician recommends hospitalization. CDPHP UBI's Utilization Management Department should be notified no later than 72 hours prior to the planned service whenever possible. This requirement does not apply to admissions for Emergency care or admissions for the delivery of a baby (except for scheduled caesarean section deliveries).

    It is the Member's responsibility to make sure that this review process is followed. After review, CDPHP UBI will notify the Member, the Member's physician and the Hospital if the care is determined to be Medically Necessary and appropriate. If CDPHP UBI's Medical Director or his/her designee determines that it is not Medically Necessary for the Member to have a service, CDPHP UBI will telephone the Member's physician. If the physician provides CDPHP UBI with additional information, CDPHP UBI's Medical Director or his/her designee may reconsider the medical necessity of the service. If CDPHP UBI's Medical Director or his/her designee does not give approval for the Member's Elective Admission prior to the Member's admission to the Hospital, the Member will be notified.

    If the Member's Elective Admission is without the Member seeking prior approval, but is subsequently determined by CDPHP UBI's Medical Director or his/her designee to have been Medically Necessary, the Member is responsible for an additional payment of 50 percent of the Allowed Amount up to a maximum of $500 for each service otherwise payable, in addition to the applicable Copayment, Deductible and/or Coinsurance. If the Member's Elective Admission is without prior approval and not Medically Necessary, CDPHP UBI will not provide any Coverage. See also Section XIII.

2. Admissions for Emergency Care or for Delivery of a Baby.

    All admissions for Emergency Care or for the delivery of a baby (except for scheduled caesarean section deliveries) should be reviewed and approved by CDPHP UBI's Medical Director or his/her designee immediately following the admission, or as soon thereafter as is reasonably possible. It is suggested that the Member comply with the following procedure: The Member, Member's physician or the Hospital should call the telephone number shown on the CDPHP UBI Membership Card within 48 hours following the Member's Emergency or maternity admission, or as soon thereafter as is reasonably possible.

3. Pre-Certification Review of Other Services.

The Member or the Member's physician must notify CDPHP UBI's Utilization Management Department when the Member's physician recommends services for the following Health Services: Skilled Nursing Facility care, Home Health Care, inpatient rehabilitation unit or facility services, prosthetic devices and Durable Medical Equipment exceeding $500.00, diabetic Durable Medical Equipment exceeding $500.00, outpatient cardiac rehabilitation Health Services beyond 36 sessions, outpatient speech therapy Health Services after beyond one visit, Inpatient Mental Health Services and Inpatient Chemical Abuse and Dependency Treatment Services.

It is the Member's responsibility to make sure that this review process is followed. After review, CDPHP UBI will notify the Member, the Member's physician and the Hospital or facility that the care is determined to be Medically Necessary and appropriate. If CDPHP UBI's Medical Director or his/her designee determines that it is not Medically Necessary for the Member to have the proposed services, CDPHP UBI will telephone the Member's physician. If the physician provides CDPHP UBI with additional information, CDPHP UBI's Medical Director or his/her designee may reconsider the medical necessity of the service. If CDPHP UBI's Medical Director or his/her designee does not give approval for the service, the Member will be notified.

If the Member fails to seek precertification prior to receiving such services, the Member is responsible for an additional payment of 50 percent of the Allowed Amount up to a maximum of $500 for each service otherwise payable, in addition to the applicable Copayment, Deductible and Coinsurance set forth in the Schedule of Benefits. See also Section XIII.

4. Prior Authorization of Accidental Dental Services.

The Member or the Member's dentist must notify CDPHP UBI's Utilization Management Department when the Member's dentist recommends Accidental Dental services beyond those required in an Emergency.

It is the Member's responsibility to make sure that this review process is followed. After review, CDPHP UBI will notify the Member, the Member's physician and the Hospital or facility that the care is determined to be Medically Necessary and appropriate. If CDPHP UBI's Medical Director or his/her designee determines that it is not Medically Necessary for the Member to have the proposed services, CDPHP UBI will telephone the Member's dentist. If the dentist provides CDPHP UBI with additional information, CDPHP UBI's Medical Director or his/her designee may reconsider the medical necessity of the service. If CDPHP UBI's Medical Director or his/her designee does not give approval for the service, the Member will be notified.

If the Member fails to seek precertification prior to receiving such services, the Member is responsible for an additional payment of 50 percent of the Allowed Amount up to a maximum of $500 for each service otherwise payable, in addition to the applicable Copayment, Deductible and Coinsurance. See also Section XIII.

5. Organ Transplant Services.

Pre-Certification Review of Organ Transplant Services

The Member or the Member's physician must notify CDPHP UBI's Utilization Management Department when the Member's physician recommends organ transplant services. The following organ transplant services must be performed at a center in CDPHP UBI's designated specialty care network: Transplantation of any organ or tissues, including bone marrow and stem cell transplantation.

It is the Member's responsibility to make sure that this review process is followed.

After review, CDPHP UBI will notify the Member, the Member's physician and the Hospital or facility that the care is determined to be Medically Necessary and appropriate. If CDPHP UBI’s Medical Director or his/her designee determines that it is not Medically Necessary for the Member to have the proposed services, CDPHP UBI will telephone the Member's physician. If the physician provides CDPHP UBI with additional information, CDPHP UBI’s Medical Director or his/her designee may reconsider the medical necessity of the service. If CDPHP UBI’s Medical Director or his/her designee does not give approval for the service, the Member will be notified.

If the Member fails to seek precertification prior to receiving such services, the Member is responsible for an additional payment of 50 percent of the Allowed Amount up to a maximum of $500 for each service otherwise Covered, in addition to the applicable Copayment, Deductible and Coinsurance. See also Section XIII.

F. Case Management Program

1. Case Management.

Case Management is the use of an individualized approach to assist Members in obtaining Medically Necessary Health Services. CDPHP UBI may provide case management for Members with a chronic, debilitating or catastrophic injury or illness. The CDPHP UBI representative providing the case management will be a licensed, certified or registered health care professional.

2. Alternative or Additional Benefits.

Notwithstanding any other provisions in this Contract, CDPHP UBI’s representative may review the Member’s health status and the plan of care of the Member’s provider to determine whether certain levels of care or services which are not included in the Member’s Contract may be desirable or appropriate.

CDPHP UBI may make available alternative or additional care which, in the judgement of the CDPHP UBI representative, is an appropriate alternative to inpatient or surgical Health Services. The provision of this alternative or additional care is a substitute for the Health Services Covered by the Contract. The Member may reject or discontinue CDPHP UBI’s proposal of any alternative or additional care at the time of the proposal or at any time thereafter.

The Member agrees that CDPHP UBI may have access to and review on a concurrent basis any of the Member’s Hospital and other medical records to evaluate alternative or additional care possibilities. Any proposal of alternative or additional care is limited to the facts and circumstances of the particular case reviewed and does not apply to any other case of that Member or to any other Member. Case Management is not a substitute for the advice and guidance of the Member’s provider.

3. Termination of Program Participation.

Either the Member or CDPHP UBI may terminate participation in the case management program at any time for any reason. CDPHP UBI will provide the Member with at least 30 days’ prior written notice of termination of the provision of any alternative or additional care under this Section. After such termination, CDPHP UBI will provide Coverage for Health Services subject to the terms and conditions of this Contract.

SECTION VI – REIMBURSEMENT OF EXPENSES FOR TREATMENT BY NON-PARTICIPATING PRACTITIONERS AND PROVIDERS

A. Claim Form

An itemized bill or a Claim Form must be submitted to CDPHP UBI at its office address set out on the face page of the Contract within 90 days after the date the Member incurs Medically Necessary Eligible Expenses for treatment of Accidental Injury or illness. All Submissions of foreign bills and/or claim forms must include English translations and U.S. Dollar amount conversions where applicable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if such itemized bill or Claim Form is furnished as soon as reasonably possible. But in no event, except in the case of legal incapacity of the Member, shall such bill or claim be reimbursed later than one year from the date on which services were provided or the course of treatment was completed.

B. Payment of Claims

CDPHP UBI will pay Eligible Expenses incurred for treatment by a non-Participating Provider, within a reasonable period of time, upon receipt of the itemized bill or Claim Form. Benefits under the Contract may be paid to the Subscriber who incurs the expense or whose Dependent incurs the expense, for which benefits become payable. All or any portion of any benefits that become payable may be paid directly to the Hospital, person, or entity rendering the services, at CDPHP UBI's option.

C. Legal Action

No action at law or in equity shall be brought to recover under the Contract prior to the expiration of 90 days after the itemized bill or Claim Form and requested supporting information, if any, has been filed in accordance with the requirements of the Contract. Nor shall such action be brought after 12 months from the completion of Health Services for which payment is sought to be recovered.

SECTION VII – EXCLUSIONS

1. Any Accidental Injury or sickness for which benefits, settlement(s), award(s) or damages are:
   a. received from a claim under:
      i. Workers' Compensation.
   b. received or payable from a claim under:
      i. Employer's Liability, or Occupational Disease Law; or
      ii. Medicare.
2. No benefits will be paid under the Contract for any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable. Any loss or portion thereof, for which benefits are provided under the Contract which are not recovered or recoverable from mandatory no-fault insurance because such loss exceeds the maximum benefits provided under such mandatory no-fault insurance shall be paid without regard to the Deductible, Coinsurance and/or Copayment provisions set forth in the Contract. Any loss, or portion thereof, for which benefits are provided under the Contract which is not received or recoverable from mandatory no-fault insurance because of a no-fault deductible shall be paid subject to the Deductible, Coinsurance and/or Copayment provisions set forth in the Contract.
3. Health Services for the treatment of Mental Health Conditions, except the following: acute mental, nervous or emotional disorders which are susceptible to short-term treatment and pose a serious threat to the mental or physical well-being of the Member; medication management (see Section IV.K) and neuropsychological testing related to a medical Diagnosis (see Section IV.C.19; 20.)
4. Prescription drugs and biologicals are excluded except for:
   a. Those received during a Covered inpatient admission to a Hospital or Skilled Nursing Facility;
   b. Those received during the course of receiving Covered Home Health Care Services;
   c. Intravenous (IV) and intramuscular (IM) prescription drugs and biologicals when provided in conjunction with an approved Home Health Care nursing care plan;
   d. Covered immunizations administered by a practitioner in his/her office;
   e. Covered allergy immunotherapy administered by a practitioner in his/her office;
   f. Diagnostic testing agents used during Covered diagnostic procedures;
   g. Intravenous (IV) and intramuscular (IM) prescription drugs or biologicals administered by a practitioner in his/her office. This Coverage does not apply to injectable fertility drugs, injectable or implantable contraceptive drugs or to intravenous (IV) and intramuscular (IM) prescription drugs or biologicals which are usually considered to be self-administered, but are being administered by the practitioner in his/her office or by a Home Health Care agency for reasons other than Medical Necessity. All determinations of medical necessity are subject to CDPHP UBI's Utilization Review process including all avenues of appeals, up to and including external review.

   A CDPHP UBI Prescription Drug Rider is required for Coverage of Prescription Drugs or biologicals that do not meet the above criteria.
5. Any Health Services rendered after the termination of Coverage (see Section III.C), except when a Member is determined to be eligible for benefits under the continuation of Coverage provisions of the Contract (see Section X).
6. Durable Medical Equipment, prosthetics, orthotics and supplies, except as explicitly in Section IV.O. of this Contract. Duplicate equipment or devices (e.g. one for home and one for school). Repair or replacement of Durable Medical Equipment, prosthetic devices or orthotic devices due to loss, misuse or neglect. Environmental control items including, but not limited to, air conditioners, humidifiers, dehumidifiers and/or air purifiers. Repairs of equipment or devices that are subject to manufacturer warranty. Charges related to the shipping, handling and/or delivery of Covered equipment or devices. Equipment or devices prescribed solely for use during sports or for employment. Computer assisted communication devices or electronic communication devices that are not implanted into the body.

Medical supplies, except for supplies associated with Covered devices or equipment that are included in the rental fee or purchase price of the device or equipment.

7. Any dental care and treatment except for the treatment of sound natural teeth needed as a result of an Accidental Injury occurring within 12 months from the date of the Accidental Injury or treatment needed due to a congenital disease or anomaly. Members whose future growth prohibits necessary treatment from being performed within 12 months of the Accidental Injury may receive an extension of the 12-month limitation.
8. Coverage for temporomandibular joint disease (TMJ) is excluded when it is dental in nature.
9. Non-Medically Necessary cosmetic services, including plastic surgery, and elective treatment for aesthetic improvement of nondisabling physical defects or problems. This exclusion shall not apply to a cosmetic operation when it is Medically Necessary, or reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Covered Dependent child which results in a functional impairment. Reconstructive surgery shall not include surgery for scar repair/revision only, where no functional defect is present. Requests for potentially cosmetic procedures and services will be subject to CDPHP UBI's Utilization Review process including all avenues of appeals (see Section XIII). Nothing herein shall be interpreted to preclude the application of Insurance Law § 4303 regarding breast reconstruction surgery after a mastectomy.
10. Health Services which are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or illness or to maintain the Member's health. The Contract only covers Medically Necessary services.
11. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as "Procedures") not proved to be safe and/or efficacious, or, because of Member's condition, an efficacious procedure that will have no effect on the outcome of the Member's illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized United States authorities or United States governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Procedures that are ineffective or are in the stage of being tested or researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a particular illness, injury or disease which have received approval from the federal Food and Drug Administration and/or the Agency for Healthcare Research and Quality may be Covered. CDPHP UBI reserves the right to determine Coverage on a case by case basis. Nothing herein shall be interpreted to preclude the application of Insurance Law §4303 regarding cancer drugs. CDPHP UBI's Medical Director or his/her designee shall have the authority to determine issues of Coverage raised under this Paragraph 11 and such determination is final as long as it is neither arbitrary nor capricious. CDPHP UBI's Medical Director's or his/her designee's determination is subject to Section XIII, CDPHP UBI's Claims and Appeals Procedures.

    In general, CDPHP UBI does not cover experimental or investigational procedures. If, in accordance with Section XIII.G. of this Contract, an external appeal agent overturns CDPHP UBI's denial, CDPHP UBI shall cover the experimental or investigational treatment. If the external appeal agent approves Coverage for an experimental or investigational treatment that is part of a clinical trial, CDPHP UBI will only cover the costs of services required to provide treatment to the Member according to the design of the trial. CDPHP UBI shall not be responsible for the cost of investigational drugs or devices, the costs of non-Health Care Services, the costs of managing research, or costs which would not be Covered under this Contract for non-experimental or non-investigational treatments.
12. Routine eye examinations or routine vision screenings other than those Covered under Sections IV.D. and IV.U., and the expense of purchasing or fitting eye glasses or contact lenses.
13. The expense of purchasing or fitting hearing aids.
14. Personal conveniences while an inpatient in a Hospital or other health care facility, such as private

room, television, barber or beauty services, guest services and similar incidental services and supplies which are not Medically Necessary as part of the care for the Member.

15. Services performed by a Member's immediate family including spouse, brother, sister, parent or child.
16. Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research, travel, school or camp.
17. Free care or care where no charge, in the absence of the Contract, would be made to the Member.
18. Benefits provided under Medicare or other governmental programs (except Medicaid and New York State Early Intervention programs), or services for which, in the absence of any Health Services plan or insurance plan, no charge would be made to the Member.
19. Any injury or illness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage for such injury or illness is provided through any governmental plan or program.
20. Travel and transportation expenses even though prescribed by a physician, except as provided in Section IV of the Contract.
21. Inpatient and outpatient Hospital services, unless arranged in advance by a physician or Medically Necessary because of an Emergency.
22. Hospital Clinic Services unless arranged in advance by a physician.
23. Benefits otherwise provided in the Contract which CDPHP UBI is unable to provide because of any law or regulation of the federal, state or local government, or any action taken by any agency of the federal, state or local government in reliance on said law or regulation.
24. Long-term therapies including Physical Therapy, speech therapy, occupational therapy, long-term physical rehabilitation and/or long-term spinal manipulation.
25. Any expense as a result of a Member’s failure to vacate his/her Hospital bed beyond the discharge time or date established by the Hospital, Member’s physician, and CDPHP UBI.
26. Orthotic shoe inserts and routine foot care. This includes services or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
27. Any Health Services resulting from a Member’s commission of a felony.
28. Non-Medically Necessary Custodial care or rest cures and services rendered for the convenience of a Member or provider. Care is considered custodial when it is primarily for the purpose of helping the Member with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, eating and taking medicine. All requests for potentially custodial procedures and services will be subject to CDPHP UBI’s Utilization Review process including all avenues of appeals (see Section XIII.)
30. Services required by an employer.
31 Dietary supplements or replacements. Not included in the exclusion is total parenteral nutrition.
32. Intensive weight loss programs.
33. Storage of blood or blood products. This does not apply to autologous (one’s own blood) blood donations. Benefits for transfusion services, including storage, for autologous donations of blood and blood components are available when associated with a scheduled, Covered Surgical Procedure.
34. Infertility services and assisted reproductive services, including the following: in vitro fertilization; ZIFT (Zygote Intrafallopian Transfer); GIFT (Gamete Intrafallopian Transfer); and all expenses related to reversal of voluntary sterilization, including vasectomy and tubal ligation, sex change procedures, cloning or medical or surgical procedures that are deemed experimental in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine.
35. Benefits or services prescribed by a physician but not expressly Covered by the Contract.
36. CDPHP UBI will not provide Coverage for non-Medically Necessary transplants of artificial or animal organs. All requests for potentially non-Medically Necessary procedures and services will be subject to CDPHP UBI’s Utilization Review process, including all avenues of appeals (see Section

XIII). CDPHP UBI will not provide Coverage for travel, food and lodging for transplant recipient or donor, or costs relating to searches or screenings beyond that provided for in Section IV.U. paragraph 3 for donors of organs to be transplanted.

37. Laboratory services are not Covered unless provided in accordance with Section IV.
38. The Member is financially liable for any non-Covered procedure, treatment or service.
39. Private duty nursing.

SECTION VIII – PRE-EXISTING CONDITIONS

In addition to the exclusions and limitations described in other sections of this Certificate, CDPHP UBI will not provide Coverage for Pre-Existing Conditions.

A. CDPHP UBI will not provide coverage for any service related to a pre-existing condition for a period of 12 months following the enrollment date of Coverage. A pre-existing condition is defined as a condition, other than pregnancy, whether physical or mental, regardless of the cause of the condition, for which medical advice, Diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date.

B. For purposes of this section, "enrollment date" means the first day of Coverage of the individual under the Certificate or, if earlier, the first day of the waiting period that must pass with respect to an individual before the individual is eligible to be Covered for benefits. For purposes of this section genetic information shall not be treated as a pre-existing condition in the absence of a Diagnosis of the condition related to such information.

C. No pre-existing condition limitation provision shall exclude Coverage in the case of:
   1. An individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage; or
   2. A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.

D. For purposes of this section, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:
   1. A group health plan as defined in the Employee Retirement Income Security Act as amended;
   2. Health insurance coverage;
   3. Part A or B of Title XVIII of the Social Security Act;
   4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
   5. Chapter 55 of Title 10, United States Code;
   6. A medical care program of the Indian Health Service or of a tribal organization;
   7. A state health benefits risk pool;
   8. A health plan offered under Chapter 89 of Title 5, United States Code;
   9. A public health plan (as defined in regulations);
   10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.§ 2504(e)).

E. In determining whether a pre-existing condition provision applies to a Member, CDPHP UBI shall credit the time the Member was previously covered under creditable coverage if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of this Certificate. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective shall also be credited.
   1. For purposes of applying the credit of such creditable coverage CDPHP UBI shall count a period of creditable coverage without regard to the specific benefits covered during the period.

F. Notwithstanding the pre-existing condition waiting period set forth in paragraph "A" above, Members eligible for a federal tax credit for payment of health insurance premiums, pursuant to the Federal Trade Adjustment Act of 2002, who have 3 months of creditable coverage prior to the enrollment date with no break in coverage greater than 63 days, shall not be subject to a pre-existing condition waiting period.

SECTION IX – CONVERSION PRIVILEGE

A Subscriber and/or Dependent is eligible to convert to the CDPHP UBI Conversion Contract effective as of the date of termination of the Member's Group Coverage, upon submitting an Application/Change Form and payment of the applicable first monthly premium within the required time. The Coverage will be issued without proof of insurability if the Application/Change Form is mailed or delivered to CDPHP UBI's office within 45 days of the date that the Member first becomes eligible to exercise the Conversion Privilege. The Conversion Privilege shall be available upon:

1. The termination of the Subscriber's employment or membership with the Group.
2. The termination of Dependent's eligibility, regardless of the time period the Member was Covered, by reason of:
    a. Reaching the maximum age set out in the Contract and/or any Riders attached to it where the Member can no longer be considered an eligible Dependent;
    b. Death of the Subscriber; or
    c. Divorce or annulment of the marriage to the Subscriber.
3. The termination of the Group Contract, for any reason. This shall not apply if the Group Contract holder has replaced the Group Contract with similar and continuous Coverage for the same Group whether insured or self-insured.

The Members shall not be eligible to convert to the CDPHP UBI Product as long as the Member is actually covered under another group or individual plan or the Member is eligible for comparable group coverage through an employer.

The Group agrees to notify Members of the right to convert to a CDPHP UBI Conversion Contract upon termination of a Subscriber's employment or membership in the Group. Such notice must be given within 15 days of the date of the event causing the termination of the Subscriber Group Coverage by mailing the notice to the Subscriber's last known address. If such notice is given more than 15 days but less than 90 days after the date of termination of Coverage under the Group Contract, the time allowed for the exercise of such Conversion Privilege shall be extended for 45 days after the giving of such notice. If such notice is not given within 90 days after the date of termination of Coverage under the Group Contract, the time allowed for the exercise of such Conversion Privilege shall expire at the end of such 90 days. The Group agrees to pay any additional administrative expenses incurred by CDPHP UBI if the Group fails to provide the notice as provided in this paragraph and the Subscriber converts to a Conversion Contract after the date on which the Conversion Privilege would have expired had notice been given, but within the extended time period for exercising that privilege upon the failure to receive notice, as provided by law.

SECTION X – EXTENSION AND CONTINUATION OF COVERAGE

A. Extension of Coverage

1. CDPHP UBI's Medical Director will make all determinations regarding whether a Member is Totally Disabled. If a Member is considered to be Totally Disabled while Covered by the Contract, Coverage for that specific disabling condition will be continued, upon termination of Coverage, during a continuous period of Total Disability.
   a. Coverage for hospitalization or surgery for the disabling condition shall continue for the lesser of:
      i. The period for which the Member, based on the decision by CDPHP UBI's Medical Directory, is determined to be Totally Disabled; or
      ii. 31 days from the date that the Member's Coverage is terminated.
   b. If Coverage is terminated due to termination of active employment, Coverage for the disabling condition will be extended for 12 months or until the Member is covered by other insurance or Group health plan which provides coverage for the diabling condition, whichever occurs first.
2. The Coverage of an unmarried Dependent child will be continued past the maximum age limitation for such Coverage if the child is:
   a. Incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the New York Mental Hygiene Law, or physical handicap and who became so incapable prior to attainment of age 19, unless eligibility for Dependent status has been extended by a Rider, in which case the age limit of the Rider shall apply; and
   b. Chiefly dependent upon the Subscriber for support and maintenance.

   To be eligible for Extended Coverage, proof of the child's incapacity and dependency must be furnished to CDPHP UBI within 31 days of the date of the child's 19th birthday, or within 31 days of the date on which Coverage would otherwise terminate.

B. Continuation of Coverage

1. If the Subscriber's Coverage under the Contract ends due to termination of employment or membership in the Group, he/she may continue Coverage. Coverage may be continued for the Subscriber and any of the Subscriber's Covered Dependents. Such Coverage is subject to the terms of the Contract. Continuation of Coverage will not be available for:
   a. Any person who is, becomes, or could be covered under Medicare; or
   b. Any person who is, becomes, or could be covered as an employee, Member or dependent by another Group Benefits Plan which does not contain any exclusion or limitation with respect to any pre-existing condition of employee, Member or dependent.
2. Under certain circumstances, a Member may be entitled to a continuation of Group health Coverage under federal COBRA rules. CDPHP UBI is not the Plan administrator under COBRA. COBRA continuation Coverage applies to Groups with 20 or more employees. If a Member is not entitled to COBRA Coverage, temporary continuation rights may be available under New York law. New York law requires that a Member who wishes continuation of Coverage must request such continuation in writing within 60 days following the later of the date of termination of employment or the date the Member is given notice of the right to continuation by the Group.

   Continuation of Coverage under New York law shall terminate on the date 18 months after the date of the Subscriber's termination from employment. In the case of an eligible Dependent of the Subscriber, continuation of Coverage shall terminate on a date 36 months after the date such person's benefits under the Contract would otherwise have terminated by reason of:
   a. The death of the Subscriber;

b. The divorce or legal separation of the Subscriber from his or her spouse;
c. The Subscriber becoming entitled to benefits under Medicare; or
d. A Dependent child ceasing to be a Dependent child under the requirements of the Contract.

In the case of a Subscriber who is determined, pursuant to Title II or Title XVI of the United States Social Security Act, to be disabled at the time of termination of employment or at any time during the first 60 days of continuation of Coverage, then the continuation of Coverage shall terminate 29 months after the date the Subscriber's Coverage under the Contract would otherwise have terminated.

Continuation of Coverage under the Contract shall terminate if the Member fails to make timely payment of the required premium. Monthly premium payments must be made in advance to the Group. Any questions regarding continuation rights should be directed to the Group or CDPHP UBI.

3. Continuation of Coverage will end at the first of the following to occur:
   a. Termination under COBRA or New York continuation rules; or
   b. The end of the period for which premium payments were made (where premium payments are not paid on time); or
   c. The date on which the Contract is terminated.
4. The Conversion Privilege described in Section IX is available when any period of continuation of benefits under this section ends.

SECTION XI – COORDINATION OF BENEFITS ("COB")

A. If any Member is eligible for services or benefits under two or more Group Benefit Plans providing or paying for Health Services rendered to the Member, the Coverage under those Group Benefit Plans will be coordinated so that up to, but no more than, the total allowable expenses during a claim determination period will be paid for, or provided by, all the Group Benefit Plans, less any Copayments or Coinsurance. The term "allowable expense" is the necessary, reasonable and customary item of expense for Health Services when the item of expense is Covered, at least in part, under any of the Group Benefit Plans involved. The term "allowable expense" shall not include expenses for dental care, vision care, prescription drugs or hearing aids. The term "claim determination period" means the Benefit Period during which allowable expenses are compared with total benefits payable in the absence of COB, to determine: (i) whether overinsurance exists; and (ii) how much each Group Benefit Plan will pay or provide. CDPHP UBI, as a secondary payor, may reduce its benefits so that the total benefits paid or provided by the Group Benefit Plan during a claim determination period are not more than total allowable expenses. The amount by which CDPHP UBI's benefits have been reduced shall be used by CDPHP UBI to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the Member for whom the claim is made.

B. Primary responsibility for providing these services or benefits will be determined in the following order:

1. The benefits of a plan that does not have a COB provision or has a COB provision which does not comply with New York State Insurance Department regulations will be primary.
2. The benefits of a plan which covers the person as an employee or Subscriber are determined before those of a plan which covers the person as a Dependent.
3. When a plan and another plan cover the child as a Dependent of different persons, called "parents":
    a. The benefits of the plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year; but
    b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c. If the other plan does not have the rule described above, but instead, has the rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
    d. The word "birthday" refers only to month and day in a Calendar Year, not the year in which the person was born.
4. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, the plan of the parent with custody of the child is primary;
    b. Then, the plan of the spouse of the parent with custody of the child;
    c. Finally, the plan of the parent not having custody of the child;

    If the specific terms of a court decree or separation agreement state that one of the parents is responsible for the health care expenses of a child, any entity obligated to pay or to provide the benefits of the plan of such parent that has actual knowledge of those terms, shall have benefits determined first. This paragraph shall not apply with respect to any claim determination period of a plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
5. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as the employee's Dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other

plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee or Member longer are determined before those of the plan which covered that person for the shorter period of time.

C. CDPHP UBI shall be entitled to:

1. Determine whether and to what extent a Member has indemnity or other Coverage for the Health Services provided under the Contract;
2. Establish priorities for primary responsibility among the Health Plans obligated to provide Health Services or indemnity benefits;
3. Release to or obtain from any other Group Health Plan any information needed to implement this provision; and
4. Recover the value of Health Services rendered to the Member under the Contract to the extent that such Health Services are covered by any other Group Health Plan with primary responsibility for paying for such Health Services.

D. The order of primary responsibility stated above shall not apply when the Member is entitled to receive Health Services or indemnity benefits under Workers' Compensation or similar law. In such case, the primary responsibility shall rest with those persons or agencies having the obligation to provide such Health Services or indemnity benefits.

E. The order of primary responsibility stated in Section XI.B. above may not apply when the Member is Covered under this Contract and Medicare. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), as amended:

1. Medicare coverage is primary when the Member is age 65 or older and:
   a. When the Member's CDPHP UBI Coverage is under a Group Benefit Plan offered by an employer with fewer than 20 employees (unless the employer is part of a multi-employer plan where at least one of the employers has 20 or more employees); or
   b. When the Member's CDPHP UBI Coverage is due to a reason other than the Subscriber's current employment status (i.e. the Subscriber is Covered as a retiree);
2. Medicare coverage is also primary when the Member's Medicare coverage is by virtue of the Member being disabled and:
   a. When the Member's CDPHP Coverage is under a Group Benefit Plan offered by an employer with less than 100 employees (or an employee organization when none of the employers employs at least 100 employees); or
   b. When the Member's CDPHP Coverage is due to a reason other than the Subscriber's current employment status (i.e. the Subscriber is Covered as a retiree); or
3. When a Member's Medicare coverage is also by virtue of the Member having end stage renal disease, Coverage under this Contract is primary for 30 months beginning the first month in which the Member becomes entitled to or eligible for Medicare benefits by virtue of the Member having end stage renal disease. After the end of such 30-month period, Medicare coverage is primary.

F. When CDPHP UBI Coverage is the primary Coverage, it will provide all necessary Health Services in accordance with the Contract. The secondary Group Health Plan may be obligated to pay any Coinsurance, Copayment or other charges not Covered by CDPHP UBI if the Member files a claim with that Group Health Plan. When CDPHP UBI Coverage is secondary, CDPHP UBI reserves the right to request that the Member submit the claim to the other Group Health Plan, recover any claim payment that the Member receives from that Group Health Plan to the extent such payment is for services actually received from or paid by that Group Health Plan, or to bill the Group Health Plan for Health Services provided or paid for by CDPHP UBI.

SECTION XII – RIGHT OF RECOVERY

If a Member receives benefits under the Contract and he/she also receives money from a third party judgment or settlement in payment for the same benefits, then CDPHP UBI may recover from such Member the reasonable value of the benefits provided. Recovery by CDPHP UBI shall be limited to amounts received by the Member for Hospital, medical and surgical services.

The Member must cooperate fully to assist CDPHP UBI in protecting its legal rights under this provision.

SECTION XIII – CLAIMS AND APPEALS PROCEDURES

A. Complaints

We hope our health plan serves you well. If you have a problem, talk with your doctor, or call or write member services. Most problems can be solved right away. Problems that are not solved right away over the phone, and any complaints or grievances that come in the mail, will be handled according to our complaint and grievance procedures described below.

CDPHP UBI will not retaliate against you for bringing concerns to our attention. We will abide by the CDPHP UBI membership certificate in any dispute over your benefits or rights as a CDPHP UBI member.

Please note: If you have a complaint or grievance regarding mental health or substance abuse benefits, contact United Behavioral Health directly at 1-888-320-9584. United Behavioral Health follows CDPHP UBI's processes for our members. In all cases, CDPHP UBI is responsible for the final level of determination.

How to File a Complaint

If you do not like some part of your CDPHP UBI coverage that does not involve a decision we have made, you may file a complaint by calling or writing to us. You can ask a designee (such as a lawyer, family member, or trusted friend) to file the complaint or grievance for you.

1. You can file a verbal complaint: To file a complaint by phone, call the member services department at (518) 641-3140 or 1-877-269-2134 Monday–Friday from 8 a.m. to 6 p.m. If we need more information to make a decision, we will tell you.

2. You can file a written complaint

- By writing us a letter, or
- By asking us for a complaint form to fill out. To get a complaint form, call us at (518) 641-3140 or 1-877-269-2134.
- Mail your complaint (form or letter) to: CDPHP UBI Quality Enhancement Department, 500 Patroon Boulevard, Albany, NY 12206-1057.

What Happens Next?

Within five workdays after we get your complaint we will send you a letter to let you know we are working on it. This letter will include the name, address and telephone number of the individual who will answer your complaint. Qualified personnel will review your complaint, or if it's a medical matter, a licensed, certified, or registered health care professional will look into it.

Within 15 workdays from when we get your complaint, we will request in writing any other information we need from you or your provider to decide your complaint. If we only get part of that information, we will ask for the missing information, in writing, within five workdays of getting the partial information.

We will give you or your designee a written decision on your complaint within 30 work days after we get your complaint, or within 30 days after we get all needed information, whichever is first. If we do not have all the information we need to decide your case by the 30th workday, we will send you a letter telling you why. We will then make a decision based on the information we have, and inform you of the decision within the next 15 workdays.

If a delay would significantly increase the risk to your health, we will decide your case and tell you our decision by telephone within 48 hours after we get all needed information, or 72 hours after we get your complaint, whichever is first. We will send you written notice of our decision in three workdays.

All written decisions also tell you how to appeal if you wish, and include any forms you need.

B. Claim (Non-Utilization Review) Determinations

You or your designee may file a claim for benefits, either verbally or in writing, by calling or writing to us. This section does not apply to utilization review determinations. For utilization review determinations, see the section titled "Utilization Review Decisions."

- Pre-service claims are requests for care which has not yet been provided to you and needs CDPHP UBI's prior approval. We will decide pre-service claim requests within 15 days after we get the

request for coverage of services. If we do not have all the needed information to decide by then, we may take up to 15 more days to decide your case. We will send you a letter by the end of the first 15-day period, telling you why we cannot make a decision. You will be given 45 days from the time we tell you why we cannot make a decision to send us the needed information.

- We will let you know ahead of time of any decision to reduce or end our coverage for ongoing care previously approved by us. We will give you enough time to appeal our decision and get a determination before coverage for the benefit is reduced or ended.
- An urgent (fast) decision can be made in cases where a delay could seriously endanger your life, health, or ability to regain the most function. (We use the "prudent layperson standard" to decide if you meet these criteria.) We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent care claims decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days.
- If you ask to extend a course of treatment for urgent care beyond a previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account your medical needs. You will be told of our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.
- If your claim involves care that has already been provided (post-service claims), we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us.

All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file a grievance.

C. Grievances

How to File a Grievance

If you do not like a decision CDPHP UBI has made, other than a medical necessity decision, you or your designee may file a grievance by calling or writing to us. This section does not apply to utilization review appeals. See the separate section titled "Utilization Review Appeals."

You have 180 days after we tell you of our decision to file a grievance.

To file a grievance by phone, call member services at (518) 641-3140 or 1-877-269-2134 Monday–Friday from 8 a.m. to 6 p.m. If we need more information to make a decision, we will tell you.

You can file a written grievance

- By writing us a letter, or
- By asking us for a grievance form to fill out. To get a grievance form, call us at **(518) 641-3140 or 1-877-269-2134.**
- Mail your grievance (form or letter) to: **CDPHP UBI Appeals Department**

500 Patroon Creek Boulevard, Albany, NY 12206-1057.

What Happens Next?

After we get your grievance, we will send you a letter within five workdays. We will tell you the name, address, and telephone number of the person who is working on your grievance.
If your case is a medical matter, a clinical peer reviewer who did not make the first decision will look at it. If your case is not medical, a qualified person who is at a higher level than the person who made the first decision will look at it.

If we need any other information to decide your grievance, we will ask you or your provider for the information within five days after we get your grievance. If you only send us some of the information we need, we will send you a letter within five workdays telling you what other information we still need.

If your grievance involves pre-service claims (request for care not yet given) we will decide it within

15 days after we get it.

If your grievance involves urgent care claims, and a fast decision is needed, we will decide it as soon as possible, taking your medical needs into account, but no later than 48 hours after we get your grievance. We will tell you of our decision with written or electronic notice to follow within three days.

If your grievance involves post-service claims (care given in the past) we will decide it within 30 days from when we get your grievance.

All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

D. Appeals

If you are not satisfied with how we decide your complaint or grievance, you have 60 work days after hearing from us to file an appeal. You can do this yourself or ask a designee to file the appeal for you. The appeal may be in writing or by phone. You can call, write a letter, or use CDPHP UBI's complaint form.

Send your appeal letter or form to: CDPHP UBI Appeals Department, 500 Patroon Creek Boulevard , Albany, NY 12206-1057 or call member services at (518) 641-3140 or 1-877-269-2134 for help.

We will send you a letter within five working days. The letter will tell you the name, address, and telephone number of the person who is working on your appeal. It will also tell you if we need more information.

Your appeal will be decided by:

- Qualified health care professionals, at least one of whom is a clinical peer reviewer who did not work on your original complaint or grievance, if your appeal involves a medical matter; or
- If your appeal is not about medical matters, people who work at a higher level than those who decided your original complaint or grievance.

When a delay would risk your health, we will let you know our decision within 48 hours after we get the information we need, or within 72 hours after we get your appeal, whichever is first. We will send you written notice of our decision within three working days.

For all other appeals, CDPHP UBI will decide within 15 days of getting an appeal for pre-service claims and within 30 days of getting post-service claims. All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

E. Initial Utilization Review Decisions

CDPHP UBI has a utilization review (UR) team made up of doctors and nurses. Qualified health care professionals make all UR decisions. If you disagree with a UR decision, our resource coordination department (1-800-274-2332) may be able to help. You, a designee, or your doctor may question any utilization review decision.

Prior Approvals and Prospective Review

You or your doctor must contact the CDPHP UBI resource coordination department to get prior approval for certain covered treatments.

For pre-service claims, decisions are made in three work days after we get the needed information, or 15 days after we receive a request for services, whichever comes first. If we do not have all the information we need by the 15th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 15-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you receive our request to provide the information to us. We will let you or your designee, and your doctor know our decision by telephone and in writing.

Concurrent Review

If you have been getting care or treatment that should be continued, or if more services are needed, we will review the request and make our decision within one work day after we get the information we need, or 15 days after your first request, whichever is first. We will let you or your designee and your doctor know our decision by telephone and in writing. We will let you know of any decision to reduce or end our

coverage for ongoing care approved by us earlier. We will give you enough time to appeal our decision and get a decision before coverage for the benefit is reduced or ended.

Retrospective Review

If we are checking on **care that has been given in the past,** we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us.

Urgent Review

An urgent (fast) decision can be made in some prior approval, prospective review, and concurrent review cases. We will make a fast decision when waiting for the above time frames could seriously endanger your life, health, or ability to regain the most function. We use a "prudent layperson standard" to decide if you meet these criteria. We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent decisions are not available for retrospective reviews.

Urgent care utilization review decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days. If you ask to extend a course of treatment for urgent care beyond the approved period of time or number of treatments, a decision will be made as soon as possible, taking your medical needs into account. We will tell you our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

Reconsideration of Reviews

If we make a decision without speaking to your doctor, your doctor may ask to speak to CDPHP UBI's medical director. This option does not apply to a retrospective review. The medical director will talk to your doctor and make a decision within one workday.

Notice of Appeal Rights

All notices of decisions from CDPHP UBI are in writing and include detailed reasons for the decision, including the medical rationale and the section of your contract upon which the decision was based.

Your options for asking for an appeal from us or the State will be explained. If you request, you may also receive, free of charge, reasonable access to or copies of all documents about your case.

If CDPHP UBI fails to make a utilization review decision within the above time frames, this can be considered the same thing as a denial, which would then be subject to appeal.

F. Adverse Utilization Review Appeals

Utilization Review Appeals

You or your designee can appeal a utilization review (UR) decision. Just call member services at (518) 641-3140 or 1-877-269-2134 to appeal any CDPHP UBI utilization review decision. In the case of past care reviews, your doctor can also make the appeal. There are two kinds of UR appeals: fast track and standard.

Use the **fast track** UR appeals process when:

- You need an OK to continue current health care, or
- You need more services added to those you are getting, or
- Your doctor thinks our plan should look at the request again right away, or
- A delay could seriously put your life, health, or ability to regain the most function in danger (based on the "prudent layperson standard"), or, your doctor believes you would suffer severe pain without the requested care or treatment.

We will decide fast track UR appeals within two work days after we get the information we need, or within 72 hours after we get your appeal, whichever is first. If we need more information to decide your case, we will immediately tell you and your provider by telephone and in writing of what we need. A clinical peer

reviewer will be available to talk with you or your designee within one work day after we get notice of the UR appeal. The decision on your appeal will not be made by the same reviewer who decided it the first time.

We will follow up with written notice to you within 24 hours after our decision. The notice will tell you the specific reasons for our decision, including the medical reason, and all options for appeal. If we deny your fast track UR appeal, you can request a standard UR appeal or an external appeal.

In all other cases (non-fast track), if you, your designee, or your doctor do not agree with what we decided, you may appeal using the **standard** UR **appeals** process.

- You must file a standard UR appeal (by phone or in writing) within 180 days of getting notice of our decision (which will tell you how to appeal).
- Within five work days, we will send you a letter telling you the name, address, and telephone number of the person who is working on your appeal.
- The decision on your appeal will not be made by the same reviewer who decided the first time.
- If we need any additional information to decide your UR appeal, we will send you or your provider a letter within five days after we get your UR appeal.
- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
- If we do not make a fast track or standard decision within the above time frames, we must allow you to get the service you or your doctor asked for.

In some cases, you can ask to skip the UR appeal step and go directly to an external appeal. If we agree to an external appeal, we will send you a letter within 24 hours. See the following section.

G. External Appeals

You may ask for an external appeal if either #1 or #2 below are true:

1. CDPHP UBI turned down your request for service, saying that it was not medically necessary. The service must otherwise be covered under your contract.
2. CDPHP UBI denied coverage for a health care service because we believe it is experimental or investigational. The following must also be true:

- Your doctor tell us that you have a life-threatening or disabling condition or disease.
- A “life-threatening condition or disease” is one that your doctor believes has a high probability of death. A “disabling condition or disease” is a health issue that can be expected to result in death, last for a year or more, or keep you from working and/or doing any age-appropriate substantial, gainful activities.
- Your doctor has
  - (a.) Recommended a service or pharmaceutical product (as described in New York Public Health Law § 4900(5)(b)(B)) that is more likely to help you than any covered care. He or she must base the request on two acceptable documents. Only certain documents will be considered. Your doctor should contact the State Insurance Department to find out more or,
  - (b.) Recommended a clinical trial for which you are eligible (only certain clinical trials are covered.)
    - i. Standard health services for your condition have not worked or are not appropriate
    - ii. There are no other covered health service that might help you
    - iii. There are no other official clinical trials that might help you.
    - iv. Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.
    - v. The care your doctor recommends would be covered under your contract if we had not decided it was experimental or investigational.

If you wish, and your case fulfills either #1 or #2 above, you and CDPHP UBI may agree in writing to waive the UR appeal step and go directly to an external appeal.

All external appeals will be conducted by agents certified by the Commissioner of the New York State Department of Health. These agents are randomly assigned to conduct external appeals.

You or your designee have 45 days after getting an adverse UR appeal decision from CDPHP UBI to ask for external appeal. Your designee may file for it on your behalf. Or, if it is a situation where the care has already been delivered, your doctor may file for the external appeal.

If you and CDPHP UBI agree in writing to waive the UR appeal step, you have 45 days after filing the waiver to submit a written request for an external appeal.

External appeal requests must be in writing on a standard New York State Insurance Department (NYSID) form. CDPHP UBI will give you a copy of this form with our UR appeal decision or our written waiver of that step. Or, you can ask for a form by calling CDPHP UBI at 1-877-269-2134 or NYSID at 1-800-400-8882. It is also available online at www.ins.state.ny.us or www.health.state.ny.us.

Having an external appeal means you give up your rights to complete the rest of CDPHP UBI's grievance process (hearing and board of directors review).

You, your designee, and your doctor may submit supporting documents to the external appeal agent during the same 45-day period. If these documents contain new information that is different from the facts CDPHP UBI used to make its UR appeal decision, CDPHP UBI may take up to three work days to consider the new facts and review its decision.

The external appeal agent will decide your appeal within 30 days of getting it. During that time, he or she may request information from you, your designee, your doctor, and CDPHP UBI. If the agent asks for more information, he or she may take up to five extra work days to decide your case. The agent will notify you and CDPHP UBI, in writing, of the decision within two work days after the decision is made.

However, if your doctor says that a delay could be an imminent or serious threat to your health, the decision will be made within three days of the request. The agent will notify you and CDPHP UBI of the decision right away, either by phone or fax. A written copy of the decision will also be sent right away.

If the external appeal goes in your favor, CDPHP UBI will cover the care in question, subject to the terms of your contract. If the agent agrees that you should be allowed to enter a clinical trial, CDPHP UBI will only cover the costs of your treatment within the trial. CDPHP UBI will not cover investigational drugs or devices that are part of the clinical trial. We also will not cover costs of the clinical trial that would not be covered under your contract, such as for research or non-health-related items.

It is the MEMBER'S RESPONSIBILITY to initiate the external appeal process. You can file an external appeal by sending a completed form to NYSID. If you already received the service in question, your doctor may file an external appeal for you, but you would need to agree to this in writing.

Under New York State law, a completed request for appeal must be filed within 45 days of either the date upon which you get written notification from us that we have upheld a denial of coverage or the date upon which you get a written waiver of the utilization review appeal step. We have no authority to grant an extension of this deadline.

H. Hearing

CDPHP UBI Grievance Committee Hearing

If you do not agree with the decision made through our appeal processes, you or your designee may ask for a hearing before the CDPHP UBI grievance committee. This option is not available if you have an external review. You must ask us for a hearing (verbal or written) within 60 work days after we tell you of our appeal decision.

The grievance committee is made up of individuals not previously involved in any of our prior decisions in your case.

We will send you a letter within five workdays after we get your request for a hearing. The letter will include the name, address, and telephone number of the person who will answer the hearing request, as well as any additional information needed.

A hearing will be held within 45 days after you make your request. The hearing will be led by the chairperson of CDPHP UBI's grievance committee or his or her designee, and will be recorded by a court stenographer. You can appear before the grievance committee, or to participate by telephone or other

appropriate technology. You may also choose a person to represent you at the hearing.

The CDPHP UBI grievance committee will send you or your representative a letter with its decision within five workdays after the hearing. The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision.

If a delay would considerably increase the risk to your health, we will make sure that the hearing is held and you get the decision within 48 hours after we get all the needed information, or 72 hours after you asked for a hearing, whichever is first, with a letter sent to you within three work days after the decision.

I. Board of Directors

If you do not agree with the decision made by the CDPHP UBI grievance committee, you can ask that the CDPHP UBI board of directors review the decision. You must ask in writing within 30 days of when you get the CDPHP UBI grievance committee decision. After we get your letter, the board of directors will review your request at its next regularly scheduled meeting. The CDPHP UBI board of directors will only consider the full record of the CDPHP UBI grievance committee hearing. The board of directors will provide you or your designee a written decision within 30 days of its meeting.

J. Complaint to the Departments of Insurance

If you are unable to resolve a problem with CDPHP UBI, you may also file a complaint anytime by contacting:

New York State Insurance Department
1 Commerce Plaza
Albany, NY 12257
1-800-342-3736
www.ins.state.ny.us

SECTION XIV – RELATIONSHIP BETWEEN PARTIES

The relationship between CDPHP UBI and Participating Providers is a contractual relationship between independent contractors. Participating Providers are not agents or employees of CDPHP UBI nor is CDPHP UBI or any employee of CDPHP UBI an agent or employee of Participating Providers.

The relationship between a Participating or non-Participating Practitioner and any Member is that of physician and patient. The Participating or non-Participating Practitioner is solely responsible for the Health Services provided to any Member. CDPHP UBI is not liable for any act, omission, or other conduct of any provider in furnishing professional, ambulatory, Hospital or any other services to Members. Nor is any Participating or non-Participating Provider liable for the acts of any other provider based solely upon his/her or its association with CDPHP UBI.

SECTION XVI – GENERAL PROVISIONS

A. Entire Contract

The Contract, the application of the Group and the Member's individual Application/Change Form shall constitute the entire Contract between the parties. All statements made by the Group or by a Subscriber shall be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Contract or be used in defense to a claim unless in writing signed by the Group and/or a Subscriber.

B. Time Limit on Certain Defense

No statement, except a fraudulent misstatement, shall be used to void the Contract after it has been in force for a period of two years.

C. Alteration

No alteration of the Contract and no waiver of any of its provisions shall be valid unless evidenced by an endorsement of an amendment attached to the Contract which is signed by the President of CDPHP UBI. No agent has authority to change the Contract or to waive any of its provisions.

D. Consent to Release of Medical Information

1. By accessing Coverage under this Contract, each Member consents to the release of all medical information, including any mental health, alcoholism and/or substance abuse treatment records and any confidential HIV related information, to CDPHP UBI (and to any professional or entity assisting CDPHP UBI in providing services, including, but not limited to, managing health care services, administering claims and pursuing proper payment of claims to such an extent as may be reasonable to enable CDPHP UBI to provide services under the Contract.
2. Unless otherwise prohibited by law, a Member gives implied consent to release medical information upon presenting his/her CDPHP UBI ID Card to any provider.
3. CDPHP UBI shall have the right to deny Health Services or to refuse reimbursement for Health Services to any Member who refuses to consent to release medical information.
4. The Member agrees to execute any releases for medical records and information which CDPHP UBI requests of the Member.

E. Forms

The Group shall keep on file copies of all documents, forms, and descriptive literature provided by CDPHP UBI for distribution to Subscribers such as, but not limited to, the Certificate and Application/Change Form. The Group agrees to give all new employees a copy of CDPHP UBI's Application/Change Form and descriptive literature, provided by CDPHP UBI, at the time that the employee is hired. Application/Change Forms shall be made available to Subscribers during the Group's regular business hours.

F. Records

1. The Group shall furnish CDPHP UBI with all information and proofs which CDPHP UBI may reasonably require with regard to any matters pertaining to the Contract. All documents furnished by the Group and any other records which may have a bearing on the Coverage under the Contract shall be open for inspection by CDPHP UBI at any reasonable time.
2. Each Member authorizes and directs any person or institution that has examined or treated the Member to furnish CDPHP UBI upon its request any or all information and records or copies of records relating to the examination or treatment rendered to the Member. CDPHP UBI shall have the right to submit any and all records concerning Health Services rendered to Members to appropriate medical review personnel.

3. In the event of a question or dispute concerning the provision of Health Services or payment for such services under the Contract, CDPHP UBI may reasonably require that a Member be examined, at CDPHP UBI's expense, by a Participating Practitioner designated by CDPHP UBI.

G. Notice

1. All notices to the parties to the Contract shall be in writing, postage prepaid, registered or certified mail, return receipt requested and shall be deemed given when mailed. The notices shall be mailed to the Group at the address on file at CDPHP UBI and to CDPHP UBI at the address indicated on the cover page of the Contract, or to such other address or person designated by either party, in writing, during the term of the Contract.
2. Notice given by CDPHP UBI to an authorized representative of the Group shall be deemed notice to all affected Subscribers in the administration of the Contract, including termination of the Contract or the termination of Members' Coverage. The Group agrees to provide appropriate notice to all affected Subscribers at its own expense.

H. Covered Benefits

In no event shall any Member be responsible to pay for Health Services Covered by the Contract except as otherwise provided in the Contract.

I. Certificate

CDPHP UBI will issue to the Subscriber a Certificate describing the Health Services to which he/she is entitled.

J. Severability

The unenforceability or invalidity of any provision of the Contract shall not affect the validity and enforceability of the remainder of the Contract.

K. Workers' Compensation Not Affected

The Coverage provided under the Contract is not in lieu of and does not affect any requirements for Coverage by Workers' Compensation Insurance.

L. Pronouns

All personal pronouns used in the Contract shall include either gender unless context indicates otherwise.

M. Conformity with Statutes

The Contract shall be governed by the Laws of the State of New York.

N. Waiver

Either party's waiver or failure to insist on strict performance of the Contract shall not be considered a waiver or act as a bar to any action for subsequent acts of non-performance.

O. Interpretation

CDPHP UBI may adopt and amend from time to time reasonable and uniform policies, procedures, rules, regulations, guidelines and interpretations in order to promote the orderly and efficient administration of this Contract, all of which shall be binding upon the Group and each Member upon reasonable notification of the Member.

P. Construction

CDPHP UBI shall have final authority to construe and interpret all terms in the Contract, including any terms that may appear unclear or uncertain. Any construction of the provisions of the

Contract adopted by CDPHP UBI in good faith shall be binding upon the Group, Subscribers and Members.

Q. Anti-Vesting

CDPHP UBI retains the right to change the Contract. CDPHP UBI will provide Members with 90 days advance notice of any such change. Any change will be considered as a termination of this contract pursuant to Section III.C. All rights vested under this Contract will be extinguished at the end of the Benefit Period during which this Contract is terminated.

CDPHP UNIVERSAL BENEFITS, INC.
500 Patroon Creek Boulevard • Albany, NY 12206-1057

AMENDMENT TO UBI CONTRACT

The Contract to which this Amendment is attached is amended as follows:

SECTION II –DEFINITIONS

40. **Mental Health Care:** Medically Necessary care rendered by an eligible practitioner or approved facility and which in the opinion of CDPHP UBI, is directed predominantly at treatable behavioral manifestations of a condition that CDPHP UBI determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
56. **Active Treatment**: treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health.
57. **Biologically Based Mental Illness**: a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such illnesses are defined as: schizophrenia/psychotic disorders, major depression, bi-polar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, anorexia
58. **Children With Serious Emotional Disturbances:** those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

SECTION IV – COVERED HEALTH CARE SERVICES

J. Mental Health Care Services.

Service

1. **Inpatient Services**

   Up to 30 days of Active Treatment per Benefit Period for diagnosis and treatment of Mental Health Care including all facility, diagnostic and physicians' charges.

   Please see Section V.E. regarding requirements of the Managed Benefits Program. Subject to the Inpatient Copayment/Coinsurance listed in Section IV.E.

   Mental Health Care Services are not subject to the Deductible.

2. **Outpatient Services.**

   The Member must contact CDPHP UBI's designated managed behavioral health care organization prior to receiving Covered Health Services from a licensed psychologist or psychiatrist, a licensed clinical social worker or professional corporation or university

faculty practice corporation. Up to a maximum of 20 visits per Benefit Period for outpatient care are Covered, whether individual or group therapy, for: diagnosis, evaluation and treatment of Mental Health Conditions. Outpatient services include care provided in a facility issued an operating certificate by the commissioner of mental health or in a facility operated by the office of mental health, or office-based Mental Health Care.

Outpatient Services are subject to the Office Based Health Services Copayment listed in Section IV.C.

Mental Health Care Services are not subject to the Deductible.

3. Inpatient and Outpatient Services shall include Coverage for adults and children with Biologically Based Mental Illness and Coverage for Children with Serious Emotional Disturbances. Coverage for these services is comparable to other medical coverage under this Contract. Please note that, although these services apply to the 30 inpatient days/20 outpatient visits limits noted in sections 1 and 2 above, Coverage is available beyond those limits for inpatient and outpatient services for adults and children with Biologically Based Mental Illness and Children with Serious Emotional Disturbances

   Services in Section IV.J.3. are subject to the Copayment and/or Coinsurance according to Section IV. of this Contract.

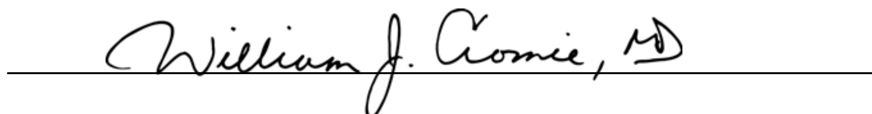
4. **Partial Hospitalization**
   Partial hospitalization treatment is Covered with two partial hospitalization days for Mental Health Care equaling one Covered Inpatient hospitalization day of Mental Health Care.

SECTION VII – EXCLUSIONS

3. This exclusion has been deleted from the Contract.

The terms of the Contract to which this Rider is attached shall remain in full force and effect, except as amended by this Rider.

CDPHP UNIVERSAL BENEFITS, INC.



William J. Cromie, MD, MBA
President and CEO

RIDER TO MODIFY SUBSCRIBER CRITERIA

The Contract to which this Rider is attached is amended as follows:

SECTION III - ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

A. Eligibility.

Individuals are accepted for enrollment when they meet the requirements outlined below:

1. Subscribers: To be eligible to enroll as a Subscriber, an individual must meet the eligibility requirements listed below and any other eligibility requirements as may be imposed by the Group and agreed to by CDPHP UBI.

   f. In the event of a Group offering other Group Benefit Plan options to Medicare-eligible employees and/or retirees in addition to the Coverage provided under this Contract, any individual who is otherwise eligible to enroll as the Subscriber's Dependent spouse is eligible to enroll as the Subscriber for the purposes of this Contract, subject to all of the terms and conditions of this Contract, except for items "b" through "e" above, provided that the Dependent spouse is not Medicare-eligible. Any Dependent spouse enrolled as a Subscriber under this Section A.1.f. is still considered a Dependent spouse for the purposes of Section III.C. below (Termination of Coverage) and Section X (Extension and Continuation of Coverage).

RIDER TO COVER FULL-TIME STUDENTS

The Contract to which this Rider is attached is amended as follows:

SECTION III - ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

A. Eligibility.

Individuals are accepted for enrollment when they meet the requirements outlined below:

2. Dependents: To be eligible to enroll as a Dependent, an individual must either be:

h. Student Dependents

i Members eligible for Coverage including unmarried Dependent children of the Subscriber who are:

- At least 19 years of age, but younger than 25 years of age;
- Not regularly employed on a full-time basis;
- A full-time student in a degree program at a licensed or accredited college or university; or, a full-time student participating in an extended course of study at a registered or licensed business or trade school leading to eligibility for licensure or certification in a vocation or technical field;

If a child Covered under this provision is required to take a medical leave of absence from school due to illness, Coverage for the child under this Contract will continue for up to one year beyond the last day of attendance in school or until the child's Coverage would otherwise terminate under this Contract, whichever occurs first. For coverage under this Contract to continue for a full-time student while on a medical leave of absence, a physician licensed in the State of New York must certify to CDPHP UBI in writing that the medical leave of absence from school is Medically Necessary. Written documentation from the school indicating the effective date of the medical leave is also required and must be submitted to CDPHP UBI within 31 days of the effective date of the approved medical leave.

ii Out of Area Benefit for Student Dependents

In addition to the Medically Necessary services, when a student Dependent is attending school in an area where CDPHP UBI does not maintain a network of Participating Practitioners and Providers, CDPHP UBI will provide additional Coverage for the following:

- Medically Necessary services rendered by non-Participating Practitioners and Providers, subject to the prior approval requirement in Section V.
- Coverage from non-Participating Practitioners and Providers does not apply during vacations and/or summer recess. If a student Dependent is enrolled in classes required toward his/her elected course of study during periods usually deemed to be vacation and/or summer recess, Coverage rendered by non-Participating Practitioners and Providers will remain in effect.
- Preventive Care for student Dependents rendered from non-Participating Practitioners and Providers which is not for the purpose of treating a particular illness, injury or disease is excluded. Preventive Care will be Covered under the Contract only when it is provided or arranged by a Participating Practitioner or Provider.
- Out of area coverage for student Dependents is not limited to students age 19 and older, as long as the other requirements in section III.A.h. are met.

iii. Prior Approval Requirement for Out of Service Area Coverage

- Except for Emergency care as provided by the Contract, prior approval must be obtained before services are rendered to student Dependents pursuant to this Contract.
- If a student Dependent has an illness, injury or disease which:
  Results in absence from classes for more than two consecutive school weeks; or
  Requires continued medical treatment for more than 60 days, then CDPHP UBI reserves the right to require the student Dependent to obtain Medically Necessary services from CDPHP UBI Participating Practitioners and Providers.

C. Termination of Coverage

A Member's Coverage shall automatically be terminated on the first of the following to apply:

3. For Subscribers, the end of the month in which the Member ceases to be eligible as a Subscriber. For Dependent Spouses in cases of divorce, the date of the divorce. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, unless the reason for ineligibility is that the Dependent child of the Subscriber becomes married. In such cases, Coverage will terminate as of the date of the Dependent's marriage. If a Dependent ceases to be a full-time student, CDPHP UBI must be notified immediately in writing.

RIDER TO EXTEND COVERAGE TO THE END OF THE CALENDAR YEAR

The Contract to which this Rider is attached is amended as follows:

SECTION III - ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

C. Termination of Coverage

A Member's Coverage shall automatically be terminated on the first of the following to apply:

3. For Subscribers, the end of the month in which the Member ceases to be eligible as a Subscriber. For Dependent spouses in cases of divorce, the date of divorce. For Dependent children who reach the maximum eligibility age limit of the Contract, the end of the Calendar Year in which the Dependent reaches the maximum eligibility age limit. For Dependent children who cease to be full-time students as defined by any applicable Rider which provides extended eligibility to full-time student Dependents, the end of the Calendar Year in which the Dependent ceases to be a full-time student. In such cases, CDPHP UBI must be notified immediately of the change in full-time student status. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, unless the reason for ineligibility is that the Dependent child becomes married. In such cases, Coverage will terminate as of the date of the Dependent's marriage.

DOMESTIC PARTNER RIDER

The Contract to which this Rider is attached is amended as follows:

SECTION III - ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

A. Eligibility.

2. Dependents: To be eligible to enroll as a Dependent, an individual must either be:
   i. The Subscriber's domestic partner who meets all of the following:
      i. In a close and committed personal domestic partner relationship with the Subscriber;
      ii. Of the same or opposite gender as the Subscriber;
      iii. At least 18 years of age;
      iv. Not related to the Subscriber by marriage or blood in a way that would bar marriage;
      v. Not married to anyone else nor have another domestic partner;
      vi. Residing in the same household with the Subscriber continuously for at least the time period agreed upon by the Group and CDPHP UBI (which is in no case greater than twelve months) and intending to do so indefinitely;
      vii. Able to provide proof, upon request, of domestic partnership with the Subscriber as defined in paragraphs "i" through "vi" above. Acceptable proof would include completion of a CDPHP Certificate of Domestic Partnership or a certificate or affidavit supplied by the Group that has been deemed equivalent by CDPHP or a registration or certificate of domestic partnership issued by the municipality in which the Subscriber resides.
      viii. Able to provide proof, upon request, of financial interdependence with the Subscriber as evidenced by two or more of the following:
         - A joint bank account
         - A joint credit or charge card
         - Joint obligation on a loan
         - Status as authorized signatory on the partner's bank account, credit Card or charge card
         - Joint ownership or holding of investments
         - Joint ownership of residence
         - Joint ownership of real estate other than residence
         - Listing of both partners as tenants on the lease of the shared residence
         - Shared rental payments of residence (need not be shared 50/50)
         - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
         - A common household and shared household expense, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
         - Shared household budget for purposes of receiving government benefits
         - Status of one as representative payee for the other's government benefits
         - Joint ownership of major items of personal property (e.g., appliances, furniture)
         - Joint ownership of a motor vehicle
         - Joint responsibility for child care (e.g., school documents, guardianship)

- Shared child-care expenses, e.g., baby sitting, day care, school bills (need not be shared 50/50)
- Execution of wills naming each other as executor and/or beneficiary
- Designation as beneficiary under the other's life insurance policy
- Designation as beneficiary under the other's retirement benefits account
- Mutual grant of durable power of attorney
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partner's financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case

CDPHP UBI reserves the right to verify that the domestic partner Dependent meets the eligibility requirements of the Contract, including this Rider.

A domestic partnership shall be deemed to terminate when one or more of the foregoing requirements cease to be satisfied. The Subscriber must notify the Group and CDPHP UBI if any of the foregoing requirements cease to be satisfied. A waiting period that is in no case greater than 12 months and is agreed upon by the Group and CDPHP UBI will be required from the date a domestic partner Dependent is no longer eligible for Coverage, until the Subscriber's new domestic partner will be deemed eligible for Coverage.

j. Unmarried dependent children of the Subscriber's domestic partner who meet the eligibility requirements that a Subscriber's child would be subject to as set forth in paragraphs "b" through "h" above. The domestic partner must be eligible for Coverage pursuant to the requirements set forth in paragraph "i" above. Coverage for children of domestic partners under this paragraph "j" will terminate in accordance with Section III.C of the Contract upon termination of the domestic partnership. The Subscriber must notify the Group and CDPHP UBI if any of the requirements for Coverage of any children of the domestic partner cease to be satisfied. CDPHP UBI reserves the right to verify that children of the domestic partner meet the eligibility requirements of the Contract.

B. Enrollment

3. A Subscriber's spouse and/or domestic partner Dependent and family member(s) may enroll other than during the Group's Open Enrollment Period when one of the following changes in status occurs and when proof of such change is presented to CDPHP UBI:
   a. marriage;
   b. birth of a Dependent;
   c. Subscriber's involuntary loss of Coverage;
   d. court-ordered Coverage for a spouse or minor Dependent; or
   e. Meeting any waiting period for domestic partner eligibility as agreed to by the Group and CDPHP UBI.
4. Special Enrollment Periods.
   b. If a person becomes a Dependent of a Member (or has met any waiting period applicable to becoming a Member and is eligible to be enrolled but for failure to enroll during a previous enrollment period) through marriage, birth, or adoption or placement for adoption, the person (or, if not otherwise enrolled, the individual) may be enrolled as a Dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a Dependent of the individual if such spouse is otherwise eligible for Coverage.

A Dependent special enrollment period under this Section III.B.4.b. shall be a period of not less than 31 days and shall begin on the later of:

i) The date Dependent Coverage is made available; or

ii) The date of the marriage, birth, or adoption or placement for adoption (as the case may be).

iii.) The date the eligible domestic partner Dependent meets the waiting period for eligibility as agreed to by the Group and CDPHP UBI.

If an individual seeks to enroll a Dependent during the first 31 days of such a Dependent special enrollment period, the Coverage of the Dependent shall become effective:

i) In the case of marriage, not later than the first day of the first month beginning after the date the completed CDPHP UBI Application/Change Form is received;

ii) In the case of a Dependent's birth, as of the date of such birth; or

iii) In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

iv.) In the case of a Domestic Partner Dependent meeting a waiting period as agreed to by the Group and CDPHP UBI, not later than the first day of the first month beginning after the date the completed CDPHP UBI Application/Change Form is received.

RIDER TO REMOVE PRE-EXISTING CONDITIONS PROVISIONS

The terms of the Contract to which this Rider is attached are amended as follows:

SECTION VIII
PRE-EXISTING CONDITIONS

This Section is deleted from the Contract.

RIDER FOR PRESCRIPTION DRUGS

This Rider amends the terms of the Contract to which it is attached as follows:

SECTION II
DEFINITIONS

53. Prescription Drugs: legend drugs that can only be legally dispensed when they are ordered by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law. This includes, Medically Necessary enteral formulas which have been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which, if left untreated, cause chronic disability, mental retardation or death, if prescribed by a physician or other duly licensed health care provider legally authorized to prescribe under Title Eight of the Education Law.

SECTION IV
COVERED HEALTH CARE SERVICES
AA. Prescription Drugs
Service

1. Coverage for Prescription Drugs is subject to the following conditions:
   a. The prescription for the drug must be filled at a pharmacy within CDPHP UBI's designated pharmacy benefit manager's network. Members may contact CDPHP UBI's Member Services Department at (518) 641-3140) or 1-877-269-2134 to determine if a pharmacy is within CDPHP UBI's designated pharmacy benefit manager's network.
   b. Only Medically Necessary doses of Prescription Drugs are Covered.
   c. The maximum supply shall be limited to a 30-day supply, the amount prescribed, or the commonly accepted unit of use, whichever is less. The mail order benefit as provided in paragraph 1.n. below is the only exception to the 30-day supply limitation.
   d. The Member must present a valid prescription for the drug written by a duly licensed health care provider at the time he/she receives the initial supply of a Covered Prescription Drug.
   e. The Member must show his/her ID Card and pay the dispensing pharmacy within CDPHP UBI's designated pharmacy benefit manager's network a $10 generic / $25 formulary brand / $40 non-formulary brand Copayment for each supply or refill of a Covered Prescription Drug. These amounts paid are not applicable to any other Deductible or Coinsurance Maximum set forth in the Contract unless otherwise indicated.
   f. Unless otherwise indicated by the prescribing provider, all Prescription Drugs will be filled with generic Prescription Drugs. For the purposes of this Coverage, "generic" Prescription Drugs are those drugs classified as "generic" by CDPHP UBI's designated pharmacy benefits manager; "formulary" Prescription Drugs are those drugs classified as "branded" or "non-generic" by CDPHP UBI's pharmacy benefits manager and are listed as "formulary brand" on CDPHP UBI's formulary; "non-formulary brand" Prescription Drugs are those drugs classified as "branded" or "non-generic" by CDPHP UBI's designated pharmacy benefits manager and are not listed on CDPHP UBI's formulary. See Section IV.Y.1.l. below for information on CDPHP UBI's formulary.
   g. Refills of Prescription Drugs shall be dispensed only as ordered by a duly licensed health care provider subject to the maximum supply limitations in paragraph IV.AA.1.c.
   h. In the event that no Participating Provider pharmacy, or no pharmacy within CDPHP UBI's designated pharmacy benefit manager's network is able to provide the ordered Prescription Drug within a reasonable time, the Member may go to any other pharmacy that can fill the prescription. Upon receipt from the Member of a completed Claim Form or documentation deemed acceptable by CDPHP UBI, CDPHP UBI will pay the Member the Eligible Expense for such Prescription Drug, less the Copayment set out in "e" above.

i. Injectable fertility drugs, injectable or implantable contraceptive drugs prescribed for non-contraceptive purposes, and intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered are Covered and must be prior approved by CDPHP UBI's Medical Director or his/her designee. These items will be subject to the Copayment set out in "e" above. This includes intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered, but are being administered by the practitioner in his/her office for reasons other than medical necessity.

j. Compounded medications are considered "brand" and must contain at least one legend ingredient which has a valid NDC number.

k. Coverage is subject to the CDPHP UBI Prescription Drug formulary that is in effect on the date the prescription is filled. The following types of Prescription Drugs may require prior approval: specialty pharmacy agents (see l. below), injectables, recombinant DNA products, immune-modulating agents, monoclonal antibodies, enteral formulas/modified solid food products, weight loss agents, compounded prescriptions, cosmetic agents used for non-cosmetic medical diagnoses and COX-2 inhibitors. It is the Member's responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in the Member being responsible for the total cost of the drug. Members may also contact the Member Services Department at (518) 641-3700 or 1-800-777-2273 or may consult the CDPHP UBI website at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is Covered or if prior approval is required.

l. Specialty pharmacy agents must be obtained at CDPHP UBI's participating specialty vendor(s.) Up to a 30-day supply is available. Specialty Drugs may be administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical or inhalation. CDPHP UBI designates drugs as specialty through evaluation of the following characteristics: frequency of dosage adjustments, frequency of severity of adverse effects and side-effects, requirements for storage, handling and/or administration, therapeutic range, frequency of required laboratory or diagnostic testing for monitoring safety or effectiveness, increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home healthcare therapy, requirements for significant on-going one-to-one patient support and education to maintain patient compliance and to ensure the proper storage/handling/administration of the drug, severity of compliance risk, need for work-life adjustments by patients or caregivers to adhere or successfully implement the therapy and limited distribution of the drug. Prescription drugs listed on CDPHP UBI's specialty drug list which require prior authorization as part of a clinical management program must be obtained at CDPHP UBI's participating specialty pharmacy vendor(s), for up to a 30-day supply, upon prior approval from CDPHP UBI. Specialty pharmacy agents used to treat the following diseases: asthma, growth hormone, hepatitis C, HIV, infertility, MS, psoriasis, pulmonary hypertension, osteo/rheumatoid arthritis, oral oncology drugs, implantable drugs used for endometriosis, prostate cancer, breast cancer, cyctic fibrosis, Gaucher disease, congenital alpha-1 inhibitor deficiency, Fabry disease, Mucopolysaccharidosis-1, anemia, neutropenia, thrombocytopenia and complications of chronic granulomatous disease or osteopetrosis must be obtained at the specialty vendor(s). Members may also contact the Member Service Department at (518) 641-3140 or 1-877-269-2134 or may consult the CDPHP UBI website at www.cdphp.com to determine whether a prescription drug is listed on CDPHP UBI's specialty drug list meets this requirement.

m. **Mail Order**

CDPHP-approved maintenance drugs for chronic conditions are available by mail order, except specialty pharmacy agents, subject to the following Copayments:

Generic Prescription Drugs

61 to 90 day supply: $25.00
31 to 60 day supply: $20.00
30 day supply or less: $10.00
Formulary Brand Prescription Drugs
61 to 90 day supply: $62.50
31 to 60 day supply: $50.00
30 day supply or less: $25.00
Non- Formulary Brand Prescription Drugs
61 to 90 day supply: $100.00
31 to 60 day supply: $80.00
30 day supply or less: $40.00

Contact the Member Services Department at (518) 641-3700 or 1-800-777-2273 for instructions on using the mail order program

n. Prescription Drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Coverage for such modified food products for any continuous period of 12 months for any Member shall not exceed $2,500.

o. Certain Covered Prescription Drugs that are prescribed generally to promote increased quality of life and are not generally prescribed for daily use to treat a potentially life-threatening or disabling progressive medical condition may be limited in Coverage based on medical necessity. All requests for potentially non-Medically Necessary supplies of these drugs will be subject to CDPHP UBI's utilization review process including all avenues of appeals.

p. Prescription Drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility in accordance with Section IV.Z. of this Contract are Covered.

q. Prescription Drugs and devices that are approved by the federal Food and Drug Administration for purposes of bone mineral density measurements and testing as provided in Section IV.D.3.g. of this Contract are Covered.

r. Contraceptive drugs and/or devices that require a prescription and are prescribed for non-contraceptive purposes are Covered.

s. Over-the-counter drugs that are included on CDPHP UBI's formulary are subject to the generic Copayment in Section IV.AA.e. above.

t. Drugs used for weight loss and/or the management of obesity require prior approval by the Medical Director or his/her designee in conjunction with approved medical management guidelines.

u. Claim Form: A CDPHP UBI Claim Form must be submitted to CDPHP UBI at its office address set out on the face page of the Contract within 90 days after the date the Member incurs Medically Necessary Eligible Expenses for prescription drugs. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if such Claim Form is furnished as soon as reasonably possible. But in no event, except in the case of legal incapacity of the Member, shall such claim be reimbursed if it is initially furnished to CDPHP UBI later than one (1) year from the date on which services were provided

2. The following items are excluded from Coverage:

a. Over-the-counter drugs that are not on the formulary, or any drug not requiring a prescription.

b. Coverage is provided under Section IV. of this Contract for Prescription Drugs that are described in this paragraph "b" as excluded from Coverage under this Rider. Please see Section IV of the Contract for Copayment and/or Coinsurance information. Prescription Drugs that meet the following criteria are excluded from Coverage under this Rider:

i) Those received during a Covered inpatient admission to a Hospital, or Skilled Nursing Facility;
ii) Those received during the course of receiving Covered Home Health Care;
iii) Intravenous (IV) and intramuscular (IM) Prescription Drugs and biologicals when provided in conjunction with an approved Home Health Care nursing plan;
iv) Covered immunizations administered by a Participating Practitioner in his/her office;
v) Covered allergy immunotherapy administered by a Participating Practitioner in his/her office;
vi) Diagnostic testing agents used during Covered diagnostic procedures;
vii) Intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals administered by a Participating Practitioner in his/her office. This exclusion does not apply to injectable fertility drugs, injectable or implantable contraceptive drugs or to intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are generally considered to be self-administered, but are being administered by the Participating Practitioner in his/her office or by a Home Health Care agency for reasons other than medical necessity. All determinations of medical necessity are subject to CDPHP UBI's utilization review process including all avenues of appeals.

c. Vitamins, except those requiring a prescription, even if they are ordered by a provider.
d. Experimental and/or investigative drugs, unless recommended by an external appeal agent. All determinations regarding requests for potentially experimental and/or investigative drugs will be subject to Section VII, Exclusions, including all avenues of appeals.
e. Devices of any type (except those devices specifically Covered in paragraph 1.q. or 1.r. above or under any additional Rider), such as, but not limited to, syringes, therapeutic devices, appliances and hypodermic needles, even if they must be ordered by the provider.
f. Refills will not be Covered if they are needed because a Member loses or misuses his/her supply of Prescription Drugs, even if such a refill is ordered by the provider.
g. Prescription refills in excess of the number specified by the provider or dispensed more than one year from the date of the provider’s original order.
h. Any drug, medicine or medication used for cosmetic purposes. All determinations regarding requests for potentially cosmetic drugs, medicine or medication used for cosmetic purposes will be subject to Section VII, Exclusions, including all avenues of appeals.
i. Drugs used in connection with a non-Covered service or a non-Covered benefit.
j. Elective nutritional supplements.
k. A separate Rider is required for the Coverage of contraceptive drugs and/or devices prescribed for contraceptive or purposes.

SECTION VII
EXCLUSIONS

4. This exclusion is deleted from the Contract.

RIDER FOR CONTRACEPTIVE DRUGS AND DEVICES

This Rider amends the terms of the Contract, including the required Prescription Drug Rider, to which it is attached as follows:

SECTION IV
COVERED HEALTH CARE SERVICES
AA. Prescription Drugs
Service

1. Coverage for Prescription Drugs is subject to the following conditions:
   - v. Contraceptive drugs and devices that require a prescription and/or insertion by a provider and are approved by the Food and Drug Administration are Covered when prescribed for contraceptive or non-contraceptive purposes, subject to the Copayments or Coinsurance set forth in the Member's required Prescription Drug Rider.

RIDER TO MODIFY COINSURANCE FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND OXYGEN

The Contract to which this Rider is attached is amended as follows:

SECTION IV – COVERED HEALTH CARE SERVICES

O. **Prosthetic and Orthotic Devices, Oxygen and Durable Medical Equipment.** Please see Section V.E. regarding requirements of the Managed Benefits Program or information about any applicable maximum benefit limitations. **Subject to 20% Coinsurance. Not Subject to the Deductible.**