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INDEPENDENT HEALTH'S
ENCOMPASS PLUS
Contract: C5

Issued by
INDEPENDENT HEALTH BENEFITS CORPORATION

Chairman,
Independent Health Benefits Corporation

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SECTION I – INTRODUCTION

Independent Health Benefits Corporation ("IHBC" or "us" or "we" or "our") hereby agrees with the Policyholder to provide the Health Care Services set forth herein to Members (or "you" or "your"), subject to the exclusions; limitations; conditions and other terms of this Contract.

This Contract is made in return for the Policyholder's application and payment of the required Premium on behalf of the group's employees, members, and dependents Covered by the Contract. The Contract shall take effect as specified in the application. 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.

This Contract is between the Policyholder and IHBC. If a copy of this Contract is given to a Subscriber (or "you" or "your"), it serves as a Certificate of Coverage describing available benefits but is not a contract between IHBC and the Subscriber.

All Coverage under the Contract shall begin and end at 12:01 a.m., Eastern Standard Time on the Effective Date of the Contract.

You may not assign any of the benefits of the Contract to any persons, corporation, or association. Any attempt to make such an assignment shall be void and, at our option, it may result in the termination of your 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: the Coverage, rules of eligibility, enrollment; and participation in IHBC as set forth in the Certificate issued to you, or any other source 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 Chair of IHBC. 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 IHBC unless in writing and signed by the Chair.

Health Care Services are Covered only when Medically Necessary.

SECTION II - DEFINITIONS

1. **Accidental Injury**: an unforeseen and unintended injury.

2. **Adoptive Child**: a child or infant as described in Section III of the Contract.

3. **Application Form**: the form completed by an applicant requesting Coverage from us and listing all Family Dependents to be Covered on the date such Coverage takes effect.

4. **Assistant Surgeon**: a surgeon who assists another surgeon during the course of a surgical procedure.

5. **Attending Physician**: a Participating Physician or Designated Physician who is primarily responsible for attending to the care of a Member with respect to any particular injury or illness when the following conditions have been met:

   a. The Member's Primary Physician must authorize the written/electronic Referral for a Participating Physician; and,

   b. The Member's Primary Physician and the office of the Medical Director must authorize the Referral for a Designated Physician.

6. **Calendar Year**: is a twelve-month period beginning January 1 and ending at midnight of December 31 of each year.

7. **Certificate**: a copy of this Contract issued to a Subscriber which sets forth the terms, conditions, and limitations of our Coverage.

8. **Change of Status Form**: the form provided by us to the Policyholder for distribution to Members who wish to change the following: add or delete Family Dependents; revise information contained in their enrollment record (i.e. name, address); or terminate Coverage.

9. **Claim Form**: the form provided by us for incurred Eligible Expenses for treatment by Health Care Providers.

10. **Coinsurance**: a charge, in addition to the Premium, which you are required to pay for certain Out-of-Network Services provided under the Contract. It is expressed as a percentage of the fee for Out-of-Network Services. You are responsible for the payment of any Coinsurance charge directly to the provider at the time that Out-of-Network Services are provided.

11. **Contract**: the fully signed and executed agreement entered into between us and the Policyholder on behalf of eligible enrolled Members.

12. **Contract Month**: is a period commencing on the first day of each calendar month and ending the last day of that month.

13. **Contract Year**: means the twelve (12) month period beginning on the Effective Date, and each following twelve (12) month period.

14. **Copayment**: a charge, in addition to the Premium, which you are required to pay per visit for certain In-Network Services provided under the Contract. It is usually expressed as a fixed dollar amount payable each time a service is provided regardless of the number of times it is provided. You are responsible for the payment of any Copayment directly to the provider when In-Network Services are provided.

15. **Coverage or Covered**: the Health Care Services reimbursed under the Contract.

16. **Deductible**: the amount payable by or on behalf of you for Out-of-Network Services rendered by a Provider in a Calendar Year. Any amounts paid for Copayments or Coinsurance shall not count toward the Deductible. The Deductible is determined as of the date(s) Out-of-Network Services were rendered, not upon receipt of claims.

17. **Designated Physician**: is a Non-Participating Physician who provides a service with respect to a particular injury or illness when the service is not available from a Participating Physician. The Referral to a Designated Physician must be authorized in advance in writing by: The Member's Primary Physician and the office of the Medical Director. Authorization in advance is not required in a Medical Emergency.

18. **Diagnosis**: the act or process of identifying or determining the nature of an illness, injury or disease through examination.

19. **Direct Payment Agreement**: a Contract issued by us directly to you, in accordance with the conversion privilege described by Section XI of the Contract, or for any other reason, which requires you to pay the Premium directly to us for that Contract.

20. **Effective Date**: the date from which you are entitled to receive Health Care Services from us. Coverage begins at 12:01 a.m. Eastern Standard Time on the Effective Date in accordance with the following:
    a. When a person makes written application for enrollment within thirty (30) days after the date he was first eligible, Coverage will be effective on the Eligibility Date;
    b. Persons failing to enroll within thirty (30) days of their Eligibility Date must wait until the next Open Enrollment Period to enroll in this plan; or
    c. When a person is eligible for a Special Enrollment and
    d. When Premiums for all persons under this Contract have been received by us.

21. **Eligibility Date:** the date(s) when a person is eligible to participate in the health benefits plan of the Group then in effect, provided that the Premium for Coverage under this Contract has been received by us. An eligible person must elect Coverage within the thirty (30) day period following the date he could first obtain Coverage (including eligible dependents) or when a person is eligible under Special Enrollment. If a Subscriber terminates Coverage for any reason other than termination of employment or membership, Coverage may be added only during the Open Enrollment Period except where the Subscriber qualifies for a Special Enrollment.

22. **Eligible Expenses**: the reasonable fees for Medically Necessary Health Care Services Covered under this Contract. Eligible Expenses only include fees for services actually provided to you. For services and items provided by Participating Providers, Eligible Expenses are the fee schedule amounts. For services and items provided by Non-Participating Providers, Eligible Expenses are the lesser of the fee schedule amount, the Non-Participating Provider's charges, the rate negotiated by us, or the 90th percentile of the Usual, Customary and Reasonable (UCR) rate for the Health Care Services rendered in the applicable geographic area for Non-Participating Providers.

23. **Family Dependent(s)**: a person meeting all the eligibility requirements set forth in Section III.

24. **Family Unit**: is the Subscriber and two (2) or more dependents.

25. **First Degree Relative**: means a biological parent, sibling or child.

26. **Group Benefit Plan(s)**: health benefit plans such as: HMO; health insurance; employer self-insurance or other group health plan that covers Subscriber or Family Dependents.

27. **Health Care Provider:** a person, who is licensed, certified or otherwise qualified under a state's laws to provide the Covered benefits authorized pursuant to such license, certification or other qualification. All Health Care Providers are independent contractors, relating to us by contract only, and are not our employees or agents.

28. **Health Care Services**: Medically Necessary services to treat your illness, injury or disease. Health Care Services do not include services which are not actually provided to you.

29. **Home Health Agency:** means a public or private agency that specializes in giving skilled nursing services in the home which possesses a valid certificate of approval or a license issued pursuant to Article 36 of the Public Health Law of New York State.

30. **Home Health Care**: a program of care provided by a licensed or certified agency engaged in providing Health Care Services including, but not limited to, skilled nursing services from an agency having a valid certificate of approval or a license issued pursuant to Article 36 of the Public Health Law of New York State. This Contract does not Cover private duty nursing or custodial care.

31. **Hospital**: an acute general care facility operated pursuant to law which (1) is primarily engaged in providing diagnostic therapeutic services for surgical or medical Diagnosis, treatment, and care for persons having illness, injury or disease by or under the supervision of a staff of duly licensed physicians; (2) has 24-hour nursing services by registered professional nurses; (3) is not (other than incidentally) a place for rest, custodial care; for the aged; or a nursing home; convalescent home; or similar institution; and (4) is duly licensed to operate as an acute general hospital under applicable state or local laws.

32. **Hospice Care**: the care and treatment of an enrolled Member who has been certified by his Health Care Provider as having a life expectancy of six (6) months or less 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 Hospital is located.

33. **Infertility**: means the inability to conceive after twelve (12) consecutive months of reasonably frequent contraceptive free, unprotected sexual intercourse with an intent to conceive. A Member who has the ability and/or history of conception but has a history of inability to carry the pregnancy to term does not meet the criteria of Infertility.

34. **Infertility Services**: means medical or surgical procedures which are Medically Necessary to diagnose or correct a malformation, disease or dysfunction resulting in Infertility, and diagnostic tests and procedures that are necessary to determine Infertility, including, but not limited to, hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound.

35. **In-Network Services/Benefits**: means Covered Health Care Services which are provided by a Participating Provider or authorized by us.

36. **Maternity Care**: means Coverage for Hospital, surgical or medical services and treatment relating to pregnancy, delivery, and postnatal care including:

    a. the services of a certified nurse-midwife under qualified medical direction affiliated or practicing in conjunction with a duly licensed facility, provided such services are not duplicative of services already provided by a physician.

    b. parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

37. **Medical Director or Chief Medical Officer**: the licensed physician designated by us to exercise general supervision over the provision of medical care rendered under this Contract.

38. **Medically Necessary**: any Health Care Services required to preserve and maintain your health as determined by acceptable standards of medical practice. The Medical Director shall have authority to determine whether any health care rendered to you is Medically Necessary and such determination is final as long as it is neither arbitrary nor capricious. The Medical Director's determination is subject to Section XV - Appeal Procedures and Section XIX - External Appeal. The Contract Covers only Medically Necessary services.

39. **Medicare**: the Health Insurance for Aged and Disabled Program established pursuant to Title XVIII of the Federal Social Security Act, as it is in effect at the Effective Date of the Contract or as that Act may be subsequently amended.

40. **Member or "you" or "your"**: a Subscriber and/or Family Dependent.

41. **Membership Card**: the card that we issue to you showing that you are entitled to Covered Health Care Services.

42. **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.

43. **Non-Covered Service(s)**: the Health Care Services not Covered by the Contract.

44. **Non-Participating Provider**: a licensed physician or other licensed or certified Health Care Provider who does not currently have a Participating Provider agreement to provide services through us; and who provides services Covered under Section V of this Contract.

45. **Open Enrollment Period**: is a period of time which we establish when the Policyholder can add new Members. The Open Enrollment Period shall occur not more frequently than once a year and usually coincides with the Renewal Date.

46. **Out-of-Network Services/Benefits**: means Covered Health Care Services that are provided or referred by a Non-Participating Provider or a Participating Provider which the Member elects to have rendered without the necessary Referral from their Primary Physician or authorization from us.

47. **Out-of-Pocket Maximum**: means the total amount of Deductible and Coinsurance to be satisfied; after which we will pay for Out-of-Network Services at one hundred percent (100%) of the lesser of the Non-Participating Provider's billed charges or as applicable; (1) the negotiated rate which the Non-Participating Provider has agreed to accept; (2) our fee schedule for such services rendered in our Service Area; (3) the Usual, Customary and Reasonable Rate (UCR) for services rendered outside our Service Area. UCR is determined at the 90th percentile. The Out-of-Pocket Maximum does not include additional amounts paid by the Member for non-Covered benefits, amounts in excess of our reimbursement and penalty amounts for failing to obtain Precertification.

48. **Participating Physician(s)**: any physician who has agreed to provide Health Care Services to you as a Participating Provider.

49. **Participating Provider(s)**: a participating Physician; Hospital; Skilled Nursing Facility; Home Health Agency; ambulance service; laboratory; or other duly licensed Health Care Provider that has a Participating Provider agreement with or through us to provide Health Care Services to you. All Health Care Providers are independent contractors, relating to us by contract only, and are not employees or agents of ours.

50. **Physical Therapy**: Medically Necessary short-term therapy, which can result in significant clinical improvement in your condition, as determined in our sole discretion.

51. **Policyholder**: the employer, association, or group which contracts with us to Cover Health Care Services for you.

52. **Preauthorization**: means authorization from us that a provider must obtain prior to receiving any of the services that are identified by this Contract as needing Preauthorization.

53. **Precertification**: means a certification from us that the Member must obtain prior to receiving any of the services that are identified by this Contract as needing Precertification in order to receive the maximum Coverage allowed under this Contract.

54. **a. PreHospital Emergency Medical Services (Ambulance)**: means the prompt evaluation and treatment of a Medical Emergency, and/or non-air-borne transportation of the Member to a Hospital; provided however, where the Member utilizes non-air-borne emergency transportation pursuant to this subsection, Coverage will be 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 condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

b. Medical Emergency: the sudden onset or behavioral condition 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 (1) 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 persons or others in serious jeopardy, or (2) serious impairment to such person's bodily functions, or (3) serious dysfunction of any bodily organ or part of such person, or (4) serious disfigurement of such person.

55. **Premium**: means the periodic amount of money we currently charge for benefits and services Covered under this Contract.

56. **Primary Physician**: means a Participating Physician who:

a. Is selected by a Member with the approval of the physician; and,

b. Is responsible for providing all primary care services including periodic examinations; immunizations; Diagnosis and treatment of illness and injury; coordinating the Member's overall medical care and record maintenance, providing twenty-four (24) hour physician Coverage; and authorizing all Referrals to Specialty, Attending and Designated Physicians.

57. **Primary Unit**: means the Subscriber and one (1) dependent.

58. **Qualified Ob/Gyn Provider**: means a Participating Health Care Practitioner who:

a. Is selected by a Member with the approval of the Qualified Ob/Gyn Provider;

b. Is duly licensed to provide obstetric and gynecological services, working within the scope of his/her practice; and

c. Practices as a

i. Physician specializing as an obstetrician/gynecologist;

ii. Physician specializing as a family practitioner;

iii. Professional midwife as authorized by Title VIII, Article 140 of the New York State Education Law and Regulations of the Commissioner of Education; or

iv. Nurse practitioner with a specialty in obstetrics/gynecology or women's health, as authorized by Title VIII, Article 139 of the New York State Education Law and Regulations of the Commissioner of Education.

A Member may select her Qualified Ob/Gyn Provider at any time and may change her Qualified Ob/Gyn Provider at any time to any other Qualified Ob/Gyn Provider.

59. **Referral**: means a written/electronic authorization for services written by a Participating Physician or by the Medical Director.

a. Members are required to have a written/electronic Referral for all specialty care services except for Medically Necessary specialty care services received from Specialty Physicians with specialties in allergy, dermatology, ophthalmology or by Participating optometrists.

b. Members are required to have a written/electronic Referral for all services from a Participating Physician who is not the Member's Primary Physician or Qualified Ob/Gyn Provider except for specialty services provided by Participating Physicians with specialties in allergy, dermatology, ophthalmology or by Participating optometrists.

c. Written authorization must be received from the Medical Director for any Out-of-Network Services to be Covered as In-Network.

d. When determined by the Medical Director in accordance with an approved treatment plan, a Referral may remain valid for the same Diagnosis for care by the same Health Care Provider for a period of time as authorized by the approved treatment plan.

60. **Renewal Date**: means the date on which this Contract renews unless earlier terminated as provided in Section X. The Renewal Date for this Contract is January 1, unless the Policyholder has entered into a written agreement with us for a different date.

61. **Rider(s)**: an amendment to the Contract purchased by the Policyholder, which adds to or deletes Coverage. In order to provide Coverage for additional and/or reduced Health Care Services, all Riders which apply to the Member's Contract are attached to the Contract or the Certificate on the Effective Date of Coverage.

62. **Semi-Private Room**: a room with two (2) or more beds in a Hospital; Skilled Nursing Facility; or other participating health care facility.

63. **Service Area:** means the eight (8) counties of Western New York including the following: Counties of Erie, Niagara, Orleans, Genesee, Wyoming, Chautauqua, Cattaraugus and Allegany in the State of New York.

64. **Skilled Nursing Facility (SNF)**: a facility providing therapeutic services to inpatients requiring medical and skilled nursing care as defined under Section 2801 of the New York Public Health Law or otherwise duly licensed or certified outside New York State and which is qualified to participate as an extended care facility under Title XVIII of the Social Security Act.

65. **Special Enrollment**: means the ability of an eligible person or dependent to participate in the health benefits plan under this Contract as described in Section III (B)(1),(2) and (3) of this Contract.

66. **Specialty Physician**: means a Participating Physician who provides services to a Member for a particular illness or injury upon written Referral from the Member's Primary Physician.

67. **Subscriber or "you" or "your"**: any person who meets all relevant eligibility requirements under Section III of the Contract, who applies and is accepted for Coverage from us and for whom the monthly Premium has been received by us.

68. **Totally Disabled**: an injury, illness or disease, which renders a working Member incapable of performing tasks of any employment. In the case of a non-working Member when, by reason of illness, injury or disease, he/she is wholly unable to engage in the normal activities of a person of the same sex and age.

69. **UCR (Usual, Customary and Reasonable):** by Usual we mean the fee regularly charged and received for a given service or supply by a provider. By Customary and Reasonable we mean the fee for a service or supply that we determine is the most standard and reasonable amount charged by providers in the locality where the charge for such services or supply is incurred. Locality means an area whose size is large enough, in our judgment, to give an accurate representation of standard charges for that type of service or supply.

70. **Urgent Care**: means the sudden onset of an illness, injury or condition that is not a Medical Emergency and is not life threatening, but requires immediate outpatient Medically Necessary Services. The Medical Director shall have the authority to determine whether any health care rendered to the Member is Urgent Care and such determination is final as long as it is neither arbitrary nor capricious.

71. **Utilization Review**: means the process of making medical management decisions and is provided by IHA's Medical Resource Management (MRM) department pursuant to Article 49 of the Insurance Law. See the Member Handbook for MRM procedures and how to appeal an MRM decision.

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 be an actual Member of a Group Benefit Plan entitled to participate through the Policyholder, must live or work in the Service Area and meet such eligibility requirements (such as length of service, active employment, etc.) as may be imposed by the group.

2. Family Dependents: To be eligible to enroll as a Family Dependent, an individual must qualify under one of the following paragraphs:

   a. Married to the Subscriber;

   b. An unmarried child of the Subscriber including any stepchild; legally adopted child; grandchild, foster child, proposed adoptive child or child for whom the Subscriber is the legal guardian who is:

      i. A Member of the Subscriber's household;

      ii. Dependent upon the Subscriber for support and maintenance; and

      iii. Less than nineteen (19) years of age, and is not on active duty in the armed forces of any country;

      iv. Adoptive non-infant children less than nineteen (19) years of age are Covered from the date we receive notification and payment for additional Premium, if any, provided that the following steps resulting in final adoption are completed:

         1) We are notified of the Coverage for the Adoptive Child within thirty (30) days of taking physical custody.

         2) the Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of taking physical custody; and

         3) no notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and

         4) consent to the adoption has not been revoked and the Subscriber retains a legal obligation for the total or partial support of the child in anticipation of adoption.

If notification and payment is not received by us on or before the thirtieth (30th) day from the date upon which the child is physically in the household of the Member, then Coverage will begin on the Policyholder's Renewal Date or during a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date.

      v. Adoptive infants are Covered from the moment of birth when the following steps resulting in final adoptions are completed:

         1) we are notified of the Coverage for the adoptive infant and receive payment of additional Premium, if any, within thirty (30) days of the date of birth; and

         2) the Subscriber takes physical custody of the adoptive infant upon release from the Hospital; and

         3) the Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of birth; and

4) no notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and

5) consent to the adoption has not been revoked and the Subscriber retains a legal obligation for the total or partial support of the infant in anticipation of adoption.

If we do not receive notification and payment of additional Premium, if any, on or before the thirtieth (30th) day from the date of birth, then Coverage will begin on the Policyholder's Renewal Date or during a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date.

Coverage of the initial Hospital stay for a newborn adoptive infant is not provided by us if a natural parent has insurance or other coverage available for the adoptive infant's care.

vi. Upon request, the Subscriber must provide us with a copy of the Subscriber's income tax form to demonstrate that the child is claimed as a dependent and, if applicable, the legal guardianship papers.

c. An unmarried child of the Subscriber including any stepchild, legally adopted child, or proposed adoptive child who is the age of nineteen (19) or over and is:

i. Incapable of self-sustaining employment because of mental illness, mental retardation or developmental disability, as defined by the N.Y.S. Mental Hygiene Law, or because of physical handicap, and

ii. Dependent upon the Subscriber for support and maintenance. The child must have been Covered by this Contract and must have become incapable prior to age nineteen (19) for 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. The dependent child, to remain eligible, must continue to be subject to the conditions set out in "i." above. Subscriber may be requested by us to provide evidence of the handicapping conditions claimed to be existing for the dependent child.

3. A new Family Dependent, because of marriage or adoption of a child, may be enrolled during an eligibility period extending for a period of thirty (30) days after the Family Dependent first becomes eligible for Coverage from us. If we do not receive notification and payment of additional Premium, if any, on or before the thirtieth (30th) day from the date the Family Dependent first becomes eligible, then Coverage will begin on the Policyholder's Renewal Date or a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date. Newborn natural children of the Subscriber shall be Covered from birth if notification is received and additional Premium paid, if any, within thirty (30) days of the date of such child's birth; otherwise Coverage begins on the date we receive notification and payment, provided such notification and payment is received by us reasonably close to the child's birth.

4. Persons not entitled to Coverage include:

a. Persons who are in the armed forces of any government other than for duty of thirty (30) days or less.

b. Any child born to a Subscriber's dependent child, except as provided in III.A.2.b.

c. Persons who on the Effective Date of the Contract are inpatients in a Hospital; Skilled Nursing Facility; or other health care facility; or receiving Home Health Care until such time as they are discharged or no longer receiving home medical care.

5. We reserve the right to examine a Policyholder'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.

6. We reserve 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 be enrolled with us only on the Policyholder's Renewal Date or within thirty (30) days of a Special Enrollment event and upon meeting the eligibility requirements imposed by the Policyholder or during Open Enrollment Periods agreed upon by both the Policyholder and us.

2. A potential Subscriber may enroll other than during the Policyholder's Open Enrollment Period when one of the following changes in status occurs ("Special Enrollment Events") and when proof of such situation is presented to us:

   a. a person becomes a dependent of the potential Subscriber through marriage, birth, adoption or placement for adoption;

   b. exhaustion of COBRA continuation Coverage;

   c. an involuntary loss of health insurance coverage resulting from a loss of eligibility or the employer's contributions towards coverage were terminated, provided that such person had such coverage at the time coverage hereunder was previously offered.

3. A Subscriber's spouse or family Member may enroll other than during the Policyholder's Open Enrollment Period when the person becomes a dependent of the Subscriber through:

   a. marriage;

   b. birth, adoption or placement for adoption, and the case of the birth or adoption of a child, the spouse of the Subscriber may enroll as a dependent if otherwise eligible.

4. Subscribers may enroll themselves and their Family Dependents during an eligibility period by completing an Application Form, available from either the Policyholder or us. The Policyholder agrees to give all newly hired employees or Members of the group our Application Form and descriptive literature as soon as they become eligible for Coverage. Such Subscribers may apply for Coverage from us within thirty (30) days of the date they become eligible for Coverage. If Subscribers do not apply within thirty (30) days of the date they become eligible they must wait until the next Open Enrollment Period or Special Enrollment event to become Covered.

5. Changes to the original Application Form must be made by completing a Change of Status Form or a new Application Form, which will be made available by us to the Policyholder for distribution to Members. The Policyholder agrees to promptly send us all Application and Change of Status Forms and to notify us if there is any change in the Subscriber's eligibility for Coverage.

6. Coverage of Subscribers and Family Dependents shall take effect on the Effective Date.

7. Subscribers or Family Dependents (other than newborn children of the Subscriber) who are confined to a Hospital; Skilled Nursing Facility; Home Health Care; or other health care facility on the date when this Coverage would otherwise take effect, will be eligible for Coverage, effective the first day following the Subscriber's or the Family Dependent's final discharge from such confinement (the date after discharge).

SECTION IV - PRECERTIFICATION REQUIREMENTS FOR OUT-OF-NETWORK SERVICES AND REVIEW OF YOUR IN-NETWORK AND OUT-OF-NETWORK HOSPITAL/SNF SERVICES

A. THIS CONTRACT PROVIDES FOR A PRECERTIFICATION PROCESS IN CONNECTION WITH ALL YOUR OUT-OF-NETWORK INPATIENT HOSPITALIZATION BENEFITS AND CERTAIN OUT-OF-NETWORK OUTPATIENT SERVICES. EXCEPT IN THE CASE OF A MEDICAL EMERGENCY, ALL OUT-OF-NETWORK INPATIENT HOSPITAL SERVICES AND CERTAIN OUT-OF-NETWORK OUTPATIENT SERVICES MUST BE PRECERTIFIED. FAILURE TO PARTICIPATE IN THE PRECERTIFICATION PROCESS WILL RESULT IN A REDUCTION OF COVERAGE OR BENEFITS.

1. Precertification is the process by which it is determined if Health Care Services are Medically Necessary. In order for the Member to receive Out-of-Network Coverage or benefits under this Contract, we must determine that your care is Medically Necessary. In order for us to make our determination, you must follow the rules set forth below.

2. Precertification of all inpatient Hospital services and certain outpatient services received Out-of-Network. Before you receive non-emergent Out-of-Network inpatient Hospital/SNF Services or certain Out-of-Network outpatient services, you or your physician must call us so that the Medical Director can review the reason for your Hospital/SNF care or requested outpatient service. The Medical Director will ascertain if the Hospital Services or requested outpatient services are Medically Necessary. This requirement applies only to non-Medical Emergency admissions to a Hospital/SNF or requested outpatient service. A list of outpatient services requiring Precertification will be provided to you along with your Certificate of Coverage Precertification does not apply to admissions for Medical Emergency care or admissions for the delivery of a baby.

It is your responsibility to make sure that this review process is followed. After the Medical Director reviews the Hospital/SNF or outpatient service, he/she will notify you, your physician, and the Hospital/SNF or the Non-Participating Provider of the requested outpatient service.

If the Medical Director determines that it is not Medically Necessary for you to have a Hospital/SNF service or requested outpatient service, a representative of ours will telephone your physician. If the physician provides us with additional information, the Medical Director may reconsider the Medical Necessity of the Hospital/SNF service or requested outpatient service.

The Medical Director will make the determination as to whether Hospital/SNF or the outpatient services are Medically Necessary within three (3) business days, provided that all reasonably necessary information has been supplied.

IF THE MEDICAL DIRECTOR DOES NOT GIVE APPROVAL FOR COVERAGE OF YOUR OUT-OF-NETWORK ADMISSION PRIOR TO YOUR ADMISSION TO THE HOSPITAL/SNF OR RECEIPT OF OUT-OF-NETWORK OUTPATIENT SERVICES FROM A NON-PARTICIPATING PROVIDER, YOU WILL BE NOTIFIED. IF YOUR ADMISSION OR RECEIPT OF OUTPATIENT SERVICES IS WITHOUT PRIOR APPROVAL OF COVERAGE BY US, YOU WILL BE RESPONSIBLE FOR THE PAYMENT OF 50% OF THE ELIGIBLE EXPENSES FOR THE SERVICE FOR EACH ADMISSION/OUTPATIENT SERVICE OTHERWISE COVERED UNDER THIS CONTRACT, IN ADDITION TO THE APPLICABLE DEDUCTIBLE/COINSURANCE IN SECTION V. D. BELOW, IF APPLICABLE AND ANY ADDITIONAL PAYMENTS.

You may appeal the decision in accordance with Utilization Review if the decision was based on Medical Necessity. See the Member Handbook for MRM procedures and how to appeal an MRM decision. If you are unable to resolve

the situation internally through Utilization Review, you may be able to appeal the decision through the External Appeal process in Section XIX of this Contract if applicable .

Notification of admissions for Medical Emergency care or for delivery of a baby. All Out-of-Network admissions for Medical Emergency care or for delivery of a baby must be reviewed and approved by the Medical Director immediately following the admission. You must comply with the following procedure: You, a family member, your physician, or the Hospital should call the telephone number shown on your Membership Card within seventy-two (72) hours following your Medical Emergency or maternity admission.

B. REVIEW OF YOUR IN-NETWORK AND OUT-OF-NETWORK HOSPITAL/SNF SERVICES.. Whenever you are admitted to the Hospital/SNF for inpatient care, the Medical Director will review your condition and your medical records at regular intervals to determine whether it is Medically Necessary for you to continue to receive inpatient care.

If the Medical Director determines it is not Medically Necessary for you to continue to have inpatient Hospital/SNF care, our representative will consult your physician. If your physician provides additional information, which, in the Medical Director's opinion, justifies inpatient Hospital/SNF care, we will approve Coverage of the care.

You may appeal the decision in accordance with Utilization Review. See the Member Handbook for MRM procedures and how to appeal an MRM decision. If you are unable to resolve the situation internally through Utilization Review, you may appeal the decision through the External Appeal process in Section XIX of this Contract.

IF WE HAVE NOTIFIED YOU THAT YOUR CONTINUED STAY IS NO LONGER MEDICALLY NECESSARY, AND YOU ELECT TO REMAIN HOSPITALIZED, THEN YOU WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES FOR THE CONTINUED STAY. WE WILL NOTIFY YOU OR YOUR PHYSICIAN AT LEAST ONE DAY BEFORE THE DAY PAYMENT OF BENEFITS FOR THE STAY WILL CEASE.

SECTION V - COVERAGE OF HEALTH CARE SERVICES

A. **Health Care Services which are Medically Necessary will be Covered or reimbursed in accordance with this Section V as follows:**

1. Participating Providers. Health Care Services received from Participating Providers will be Covered in conformance with Section V.D., Schedule of Coverage under the In-Network benefits.

2. Non-Participating Providers. Subject to Precertification requirements, Health Care Services rendered by Non-Participating Providers will be Covered in conformance with Section V.D., Schedule of Coverage under Out-of-Network benefits.

B. **Fee Schedule.**

1. We have approved a Fee Schedule for the Health Care Services described in this Contract. Upon request, a fee will be set for any Health Care Service not listed in the Fee Schedule. The Fee Schedule determines the maximum amount we will pay for Health Care Services from a Participating Provider.

2. You may examine the Fee Schedule that is relevant to the requested Health Care Service at our office during regular business hours. The Fee Schedule is also on file in the Office of the Superintendent of Insurance of the State of New York. The Fee Schedule may be changed by us from time to time without notification to you.

C. **Payments, Copayments, Deductibles, Coinsurance, Additional Payments and Out-of-Pocket Maximums.**

1. **Coverage for Medically Necessary In-Network Health Care Services are subject to applicable Copayments.**

2. **Coverage for Medically Necessary Out-of-Network Services are subject to the following Deductibles and Coinsurance payments unless otherwise stated:**

a. Coverage is subject to a $1,000 Deductible per person per Calendar Year. However, once two (2) family members have each met their individual Deductible, a family Covered under this Contract shall only be subject to a $2,000 total Deductible in a Calendar Year, and the other members of the family will be considered to have met their Deductible for that Calendar Year.

b. In addition to Deductibles, you must pay Coinsurance equal to 30% (50% Coinsurance for mental health services and DME) of the lesser of the Fee Schedule amount, the Non-Participating Providers charges, the rate negotiated by us, or the 90th percentile of the Usual, Customary and Reasonable (UCR) rate for the Health Care Service rendered in the applicable geographic area for Non-Participating Providers. After you have met the annual Deductible, we will pay 70% (50% for mental health services and DME) of the lesser of Non-Participating Providers Charges, the amount set forth on the Fee Schedule for the Health Care Services, the rate negotiated by us, or the 90th percentile of UCR rate for the Health Care Service rendered in the applicable geographic area for Non-Participating Providers.

3. **Additional payment.** The charges of Non-Participating Providers may exceed the amount of reimbursement we pay. Therefore, in addition to Deductibles and Coinsurance, you must pay the difference between our reimbursement and the balance due the Non-Participating Provider.

4. **Out-of-Pocket Maximums**. The maximum Deductible and Coinsurance amount that each Member pays out-of-pocket under this Contract is limited to $5,000 per person, $10,000 per family per Calendar Year. Additional payments to a Non-Participating Provider, Copayments to a Participating Provider, and any penalties due to failure to Precertify do not count against the Out-Of-Pocket Maximum.

D. SCHEDULE OF COVERAGE. COVERAGE IS SUBJECT TO EXCLUSIONS IN SECTIONS VIII and IX BELOW AND THE LIMITATIONS OF THIS CONTRACT. **CERTAIN SERVICES AS DESCRIBED IN OUR MATERIALS PROVIDED TO YOU WITH A CERTIFICATE OF COVERAGE MAY REQUIRE PREAUTHORIZATION OR PRECERTIFICATION PURSUANT TO SECTION IV OF THIS CONTRACT IN ORDER FOR YOU TO RECEIVE COVERAGE.**

a. Medically Necessary In-Network Services will be Covered subject to applicable Copayments as set forth below.

b. Medically Necessary Out-of-Network Services will be Covered as set forth below, subject to applicable Deductibles, Coinsurance and additional payments.

1. Professional Services in an Office Setting.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
1.1	Office Services subject to a Copayment for each visit to the office of the Health Care Provider.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.2	Home Visits.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
1.3	Diagnostic X-Ray, such as Organ Scans, Sonogram and Ultrasound. The Copayment for these services is in addition to any Copayment for office services which may apply.	$20 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.4	Laboratory Services.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.5	Mammography Screening for occult breast cancer, subject to the following schedule: a. Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer or if your First Degree Relative has a prior history of breast cancer; b. A single baseline mammogram for women aged thirty-five (35) through thirty-nine (39), inclusive; c. An annual mammogram for women aged forty (40) and older.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.6	Periodic Routine Health Examinations.	$15 Copayment.	Not Covered.
1.7	Well-child visits (including a medical history; physical examination; developmental assessment; anticipatory guidance; necessary and appropriate immunizations; and laboratory tests ordered at the time of the visit) for dependent children from birth through the attainment of the age of nineteen (19), provided further that the visits are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics, as follows: a. Visits: by 1 month; 2 months; 4 months, 6 months; 9 months; 12 months; 15 months; 18 months.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	b. Ages 2-5: One (1) visit per year. c. Ages 6-19: One (1) visit every two (2) years.		
1.8	Voluntary Family Planning.	Subject to applicable Copayment for specific service provided.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.9	Casts and Dressings.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.10	Obstetrical Services, including, but not limited to, Prenatal Care, Prenatal Case Management, Delivery and Post-Partum Care.	Prenatal visits will not be subject to a Copayment from Diagnosis of pregnancy up to, including, Delivery of child (or children) and Post-Partum visit. Prenatal Case Management requires Preauthorization under this Contract.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract. Payments for Prenatal Care, Delivery and Post-Partum Care will normally be made after delivery; when necessary payments will be made at reasonable intervals for services rendered for Prenatal Care and a separate payment for the Delivery and Post-Partum Care provided.
1.11	Allergy Tests and Allergy Injections.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.12	Hearing Examinations ordered by a Physician.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.13	Surgical Procedures when performed in the office.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.14	Immunizations for Members over age nineteen (19).	$15 Copayment. If the only office service is for an Influenza or Pneumonia immunization, there is no Copayment.	Not Covered.
1.15	Surgical Care and Anesthesia.	Surgical Care: $15 Copayment. Anesthesia: Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract. Multiple surgical procedures performed during the same operative session and through the same incision shall be reimbursed in an amount not

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
			less than the amount we would pay for the most expensive procedure then being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the amount we would pay for the most expensive procedures then being performed, and with regard to the less expensive procedures, in an amount at least equal to 50% of the amount we would pay for these procedures.
1.16	Infertility Services. In order to be eligible for Infertility Services, the Member must: a. be at least twenty-one (21) years of age and no older than forty-four (44) except for Diagnosis and treatment for a correctable medical condition which incidentally results in Infertility; b. have a treatment plan submitted in advance to us by a physician who meets the applicable training, experience and other standards for the Diagnosis and treatment of Infertility as promulgated by New York State and c. have a treatment plan that is in accordance with standards and guidelines established and adopted by the American Society for Reproductive Medicine. THIS BENEFIT DOES NOT COVER TREATMENT FOR THE MEMBER'S PARTNER, IF THE PARTNER IS NOT OUR MEMBER. This benefit does not include prescription drugs.	Subject to applicable Copayment for specific service provided.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.17	Annual Cervical Cytology Screening for women eighteen (18) or older	Covered in Full.	Subject to Deductibles, Coinsurance and additional

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	including: a. pelvic exam; b. pap smear collection and preparation; c. laboratory and diagnostic services provided in connection with examining and evaluating the pap smear.		payments set forth in Section V.C. of this Contract.
1.18	Chemotherapy.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.19	Radiation Therapy.	$20 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
1.20	Bone Mineral Density Measurements or tests, drugs and devices pursuant to the criteria of the federal Medicare program and the criteria of the National Institutes of Health (NIH) for the detection of osteoporosis. This benefit provides Coverage for Members meeting the criteria under the federal Medicare program or the NIH who, at a minimum: a. have been previously diagnosed as having osteoporosis or have a family history of osteoporosis; or b. have symptoms or conditions indicative of the presence or the significant risk of osteoporosis; or c. are currently on a prescribed drug regimen that poses a significant risk of osteoporosis; or d. have lifestyle factors to such a degree as posing a significant risk of osteoporosis; or e. are of such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.	$20 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

2. Physicians' Services when the Member is in the Hospital; Skilled Nursing Facility; or an Outpatient Facility.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
2.1	Surgical Procedures including Assistant Surgeon. This includes breast reconstruction surgery on one or both breasts after a mastectomy as deemed appropriate by the Attending Physician in consultation with the Member to produce a symmetrical appearance. There is also Coverage for physical complications associated with all stages of mastectomy including lymphedemas and prostheses required because of a mastectomy.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.2	General and Local Anesthesia Services.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.3	Radiotherapy Treatment.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.4	Burn Treatment.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.5	Surgical Pathology.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.6	Obstetrical Services, including, but not limited to, Prenatal Care, Prenatal Case Management, Delivery and Post-Partum Care.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract. Payments for Prenatal Care, Delivery and Post-Partum Care will normally be made after delivery; when necessary payments will be made at reasonable intervals for services rendered for Prenatal Care and a separate payment for the Delivery and Post-Partum Care provided.
2.7	Initial Newborn Care.	Covered In Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
2.8	Inpatient Professional Care while the Member is a bed patient in the	Covered in Full.	Subject to Deductibles, Coinsurance and additional

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	Hospital or SNF.		payments set forth in Section V.C. of this Contract.
2.9	Dialysis Services.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

3. Inpatient Hospital Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
3.1	Semi-Private Room.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	These services require Precertification pursuant to Section IV of this Contract. If Precertified, we will Cover such services, subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
3.2	Inpatient care for lymph node dissection, lumpectomy or mastectomy. Length of stay to be determined by Member's Attending Physician in consultation with Member.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract	These services require Precertification pursuant to Section IV of this Contract. If Precertified, we will Cover such services, subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
		are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	
3.3	Each Member requiring Maternity Care shall be entitled to Maternity Care, provided that other than care for prenatal complications, such Maternity Care shall include patient Hospital care for mother and newborn for at least forty-eight (48) hours after childbirth for any delivery other than a caesarian section, and for at least ninety-six (96) hours after a caesarian section. The mother shall have the option to be discharged earlier than provided above, in which case the inpatient Hospital care shall include at least one Home Care visit.	$500 Copayment. Early discharge Home Care visit is Covered in Full. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	Subject to Deductibles and, Coinsurance and additional payments set forth in Section V.C. of this Contract. Early discharge Home Care visit is Covered in Full.
3.4	Newborn and Infant Nursery Care.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
3.5	Intensive/Cardiac Care.	$500 Copayment. These services require Preauthorization under this Contract.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
		Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	

4. Outpatient Hospital Services or Ambulatory Surgery Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
4.1	Use of Operating and Recovery Room for Ambulatory Surgery.	$75 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.2	Diagnostic X-Ray, such as Organ Scans, Sonogram and Ultrasound. The Copayment for these services is in addition to any Copayment for office services which may apply.	$20 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.3	Outpatient Services subject to a Copayment for each visit to the Hospital.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.4	Chemotherapy.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.5	Radiation Therapy.	$20 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.6	Preadmission Testing if performed in Hospital facilities prior to a scheduled admission. The tests must be	Subject to applicable Copayment for specific service provided.	Subject to Deductibles, Coinsurance and additional payments set forth in Section

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	Medically Necessary and consistent with the Diagnosis and treatment of the condition for which surgery is to be performed; reservation for a Hospital bed and operating room are made prior to the tests; surgery takes place within seven (7) days of the presurgical tests; and the Member is physically present at the Hospital for the test.		V.C. of this Contract.
4.7	Pulmonary Rehabilitation: Twenty-four (24) visits per Calendar Year. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$15 Copayment. These services require Preauthorization under this Contract.	These services require Precertification under Section IV of this Contract. If Precertified, such services will be Covered subject to Deductibles and Coinsurance set forth in Section V.C. of this Contract.
4.8	Dialysis Services.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
4.9	Laboratory Services.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

5. Medical Emergency Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
5.1	Medical Emergency Services.	$50 Copayment.	$50 Copayment.
5.2	PreHospital Emergency Medical Services (Ambulance). Ambulance services must be provided by a licensed ambulance, must be Medically Necessary and required as a result of a Medical Emergency. Services include Medically Necessary ambulance services between Hospitals, and between a Hospital and SNF. Use of ambulance services other than PreHospital Emergency Medical Services will be reviewed retrospectively for Medical Necessity.	$25 Copayment.	$25 Copayment.
5.3	Urgent Care Services.	Subject to applicable Copayment for specific service provided.	A Member is entitled to Urgent Care Services outside the Service Area provided that the Member is unable to obtain care within the Service Area. Medically Necessary Services required due to the Urgent Care condition will be Covered until the Member

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
			can reasonably access care within the Service Area by a Participating Provider. We will reimburse Urgent Care Services provided outside the Service Area including all Preauthorized follow-up care at the lesser of billed charges or the 90th percentile of UCR minus the applicable Copayment. Urgent Care Services provided in a Hospital Emergency Room are subject to the applicable Emergency Room Copayment. All other Urgent Care Services are subject to the applicable In-Network Copayment for Physician Office Services as provided in Section V.D.1.1; this Copayment will apply per date of service per provider, even if the services rendered by the provider would not require a Copayment if the services were provided in the Service Area. In addition to the Copayment, the Member is responsible for paying the difference, if any, between our reimbursement and the Urgent Care provider's charges. **The Member or someone on his/her behalf, must contact us prior to obtaining Urgent Care Services and related Medically Necessary follow-up or subsequent care out of the Service Area in order for the services to be Covered.**

6. Acute Mental Health Care Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
6.1	Inpatient Services – Acute Mental Health Care up to thirty (30) days per Calendar Year for all facility and diagnostic charges, and up to twenty (20) inpatient visits by a Health Care Provider. The day limits are combined In-Network and Out-of-Network.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment	These services require Precertification under Section IV of this Contract. If Precertified, we will Cover such services subject to Deductibles, 50% Coinsurance and additional payments set forth in Section V.C. of this Contract.

	Chronic mental health conditions are not a Covered benefit. Payment for services for chronic mental conditions is the Member's responsibility.	requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	
6.2	Outpatient Services – Up to a maximum of twenty (20) visits per Calendar Year whether individual or group therapy for evaluation and treatment of acute mental health conditions. The visit limits are combined In-Network and Out-of-Network. Chronic mental health conditions are not a Covered benefit. Payment for services for chronic mental conditions is the Member's responsibility.	50% Copayment. These services require Preauthorization under this Contract.	Subject to Deductibles, 50% Coinsurance and additional payments set forth in Section V.C. of this Contract.

7. Alcoholism, Alcohol Abuse, and Substance Abuse Treatment Providers.

	SERVICE OR BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
7.1	Inpatient Services – Medically Necessary detoxification for alcoholism, alcohol abuse and substance abuse or addiction.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any	Not Covered.

		two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	
7.2	Outpatient services. Up to sixty (60) visits per Calendar Year for Diagnosis and treatment of alcoholism; alcohol abuse; and substance abuse. On a family policy, up to twenty (20) of the sixty (60) visits may be used for family therapy related to alcoholism; alcohol abuse; or substance abuse by a Covered Family Member. In-Network Services plus Out-of-Network Services combined equals the total benefit. Limitations: a. Services must be provided in: Facilities in New York State which are certified by the Division of Alcoholism and Alcohol Abuse or the Division of 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 services must be provided pursuant to a treatment plan, which has been submitted by the facility to us within ten (10) days of the first treatment and approved in writing by the Medical Director. Services rendered after the initial ten (10) day period will not be Covered without Medical Director approval of the treatment plan. c. Persons whose primary Diagnosis is alcohol abuse or alcoholism may be treated only in a facility certified to treat such Diagnoses.	$15 Copayment. These services require Preauthorization under this Contract.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	d. Persons whose primary Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnoses. e. Care must be as a result of alcohol dependence or substance dependence. f. Treatment of associated health conditions will be Covered under basic Health Care Services of the Contract.		

8. Skilled Nursing Facility Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
8.1	Up to forty-five (45) days per Calendar Year in a Semi-Private Room; must be ordered by a Member's physician as an alternative to Hospitalization. Central supply items, drugs, medications, biological and vaccines are Covered when provided by a Skilled Nursing Facility. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	These services require Precertification under Section IV of this Contract. If Precertified, such services will be Covered subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

9. Home Health Care Providers.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
9.1	When ordered by a physician and approved in writing by the Medical Director as an alternative to Hospitalization or treatment in a Skilled Nursing Facility (as defined in	$15 Copayment per visit. These services require Preauthorization under this Contract.	These services require Precertification under Section IV of this Contract. If Precertified, such services will be Covered Subject to Deductibles,

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	42 USC Sec. 1935 et. seq). Limited to forty (40) visits per Calendar Year. Up to four (4) continuous hours of home health aide services are counted as one home care visit. The Covered services include part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; part-time or intermittent home health aide which consists primarily of caring for the patient; physical, occupational or speech therapy if provided by the home health service or agency, medical supplies. The Medical Director has the right to determine if home care is Medically Necessary. This determination can be made at any time during an episode of care. Drugs and medications, including Home Infusion therapy prescribed by a physician, and laboratory services by or on behalf of the home health agency 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. Medically Necessary home infusion is covered and does not count against the forty (40) visit limit. Long-term physical therapy, long-term rehabilitation, private duty nursing, respite care and custodial care are excluded. In-Network Services plus Out-of-Network Services combined equals the total benefit.		Coinsurance and additional payments set forth in Section V.C. of this Contract.

10. Second Surgical Opinions.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
10.1	Second Surgical Opinions.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

11. Durable Medical Equipment (DME) and Prosthetic Devices and Medical Appliances.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
11.1	DME is equipment which: a. Is able to withstand use by more	Subject to 50% Copayment up to an annual limit of $1,000 for both In-Network and Out-of-Network	These services require Precertification under Section IV of this Contract. Subject to

	than one person; b. Is primarily and customarily used to serve a medical purpose; c. Is not useful in the absence of illness or injury; and d. Is for use in the home. We may determine to rent, purchase, and repair or replace DME, at our sole discretion. Replacement, repair, and maintenance is Covered when functionally necessary if it is not Covered under a manufacturer's warranty or purchase agreement. We will determine what is considered DME that is safe and sufficient for a Member.	DME combined. These services require Preauthorization under this Contract.	Deductible and 50% Coinsurance up to an annual limit of $1,000 for both In-Network and Out-of-Network for DME combined and additional payments set forth in Section V.C. of this Contract.
11.2	Prosthetics are devices which replace all or part of a body organ (e.g., artificial eyes, artificial limbs and ostomy supplies. Medical Appliances are devices which are used to support a weak or deformed part of a body (e.g. trusses, rigid and semi-rigid devices which support the orthopedic system.	50% Copayment. These services require Preauthorization under this Contract.	Not Covered.

12. Physical Therapy, Speech and Occupational Therapy Services.

	SERVICE OR BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
12.1	We will pay for short-term physical, occupational and speech therapy when your physician and our Medical Director determine that such services are Medically Necessary and can be expected to result in the significant improvement of your condition. Such services are allowable up to two (2) consecutive months, beginning with the first treatment. This benefit is administered on a per Diagnosis, per Calendar Year basis for such treatments on an outpatient basis. Long-term therapy is not Covered and payment for long-term therapy is your responsibility. In-Network services plus Out-of-Network services cannot exceed more than two (2) consecutive months per	$15 Copayment. These services require Preauthorization under this Contract.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	diagnosis per Calendar Year.		

13. Acute Inpatient Medical Rehabilitation Therapy.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
13.1	Inpatient treatment in an approved rehabilitation unit or facility which can result in a significant clinical improvement in a Member's condition. Must be prior approved by the Medical Director after a Hospital stay for the same injury or illness. Admission must be within one (1) day of Hospital discharge and is limited to a maximum stay of forty-five (45) days at the discretion of the Medical Director. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$500 Copayment. These services require Preauthorization under this Contract. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	These services require Precertification under Section IV of this Contract. If Precertified, we will Cover such services subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

14. Hospice Care Provider.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
14.1	Inpatient Services – Care in a hospice or in a Hospital including Medically Necessary supplies and drugs. Limitations – A total of two-hundred-ten (210) days as an inpatient and outpatient combined will be Covered. Total days of Hospice Care are computed from the first day on which any Hospice Care is provided. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$500 Copayment. Each Member is responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to only one (1) confinement per Calendar Year. Members under a family Contract are responsible for a $500 Copayment per continuous confinement for Hospital/SNF services. This Copayment requirement shall apply to any two (2) confinements per Calendar Year for Members under a family Contract, including two (2) confinements per Calendar Year	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
		for the same family member. The remaining inpatient Hospital/SNF will be Covered in Full for that Calendar Year. SNF services are limited to forty-five (45) days per Calendar Year.	
14.2	Outpatient Services – Home care and outpatient services provided by hospice including Medically Necessary supplies and drugs. Limitations – A total of two hundred ten (210) days as an inpatient and outpatient combined will be Covered. Total days of Hospice Care are computed from the first day on which any Hospice Care is provided. In-Network Services plus Out-of-Network Services combined equals the total benefit.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
14.3	Family visits – Five (5) visits for bereavement counseling, either before or after the terminally ill Member's death.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
14.4	Advance Care Planning (ACP) prior to admittance to a hospice program or facility. The Member shall be eligible for a maximum of six (6) ACP visits per Calendar Year of this benefit in addition to the Hospice Care Provider benefit. Advance Care Planning (ACP) means home visits from a program sponsored by a hospice, to assist the Member with preparation for issues following a life threatening/terminal diagnosis. In-Network visits plus Out-of-Network visits equals the total benefit.	Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

15. Diabetic Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
15.1	Medically Necessary insulin, oral agents for controlling blood sugar, diabetic supplies and equipment when recommended or prescribed by a physician or other licensed Health Care Provider: a. Medically Necessary durable	a. $15 Copayment.	a. Subject to Deductibles,

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	medical equipment for the management of diabetes. This equipment includes items such as: injection aids, insulin pumps and appurtenances thereto, insulin infusion devices, data management systems, blood glucose monitors and blood glucose monitors for the visually impaired.	Preauthorization by the Medical Director is required for Medically Necessary durable medical equipment for the management of diabetes.	Coinsurance and additional payments set forth in Section V.C. of this Contract.
	b. Subject to the Independent Health Formulary, up to a thirty (30) day supply of test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, and cartridges for the visually impaired.	b. $15 Copayment per item.	b. Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
	c. Subject to the Independent Health Formulary, up to a thirty (30) day supply of insulin and oral agents for controlling blood sugar.	c. The lesser of an $15 Copayment or the Copayment under any pharmacy Rider attached to this Contract.	c. Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.
	d. Medically Necessary self-management education and education relating to diet for persons Diagnosed with diabetes provided by the physician or other licensed Health Care Provider legally authorized to prescribe under Title Eight of the Education Law, or their staff, as part of an office visit for diabetes Diagnosis or treatment or by a certified nutritionist, certified dietician or registered dietician upon the Referral of a physician or other licensed Health Care Provider legally authorized to prescribe under Title Eight of the Education Law.	d. $15 Copayment.	d. Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

16. Chiropractic Services.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
16.1	Medically Necessary Chiropractic Care: Coverage will be provided for care by a licensed chiropractor for the purpose of removing nerve interference and the effects thereof	$15 Copayment. The Health Care Provider must obtain Preauthorization prior to treating the Member; however, the	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	which are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column, when determined to be a Medically Necessary service by the Medical Director. This care must be provided in connection with the detection or correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body.	Member will not be held responsible if the Health Care Provider renders treatment without Preauthorization.	

17. Second Medical Opinion Regarding Cancer.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
17.1	Second Medical Opinions Regarding Cancer: A Member who receives a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer is entitled to a second medical opinion by an appropriate Specialty Physician, including but not limited to a Specialty Physician affiliated with a specialty care center for the treatment of cancer.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

18. Diagnostic Screening for Prostate Cancer.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
18.1	Diagnostic screening for prostate cancer. Coverage for standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen (PSA) test is available to men who are any age having a prior history of prostate cancer. Coverage for annual standard diagnostic examination including, but not limited to, a digital rectal examination and prostate specific antigen test is available for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over having family history of prostate cancer or other prostate cancer risk factors.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

19. Blood Plasma and Packed Blood Cells.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
19.1	Blood plasma and packed blood cells, except when participation in a	Covered in Full.	Subject to Deductibles, Coinsurance and additional

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
	volunteer blood replacement program is available to the Member.		payments set forth in Section V.C. of this Contract.
19.2	Medically Necessary autologous blood.	20% Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

20. Cardiac Rehabilitation.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
20.1	Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to thirty-six (36) visits per event. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$15 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

SECTION VI - LIMITATIONS OF COVERAGE

A. **Non-Participating Providers.**

1. You must obtain Covered Health Care Services from Participating Providers and have received a Referral when Necessary to receive the Coverages stated in Section V "In-Network" provisions.

2. Health Care Services from Non-Participating Providers can be obtained by you subject to the "Out-of-Network" provisions of Section V of this Contract. If services are obtained from Non-Participating Providers, you will submit your own claim forms to us and you will be responsible for payment to the Non-Participating Provider.

B. **Medical Emergency Health Care Services.**
You are responsible for the applicable Copayment for Emergency room Health Care Services unless you are admitted to the Hospital within twenty-four (24) hours of the Emergency room services for the same illness or injury. Members must contact us within forty-eight (48) hours of receiving Emergency room treatment. Whether you seek treatment at a Participating or Non-Participating Hospital, the Emergency room charges will be paid in full, subject to the same applicable Copayment in the provisions above.

C. **Maximum Lifetime Benefit.**
There is a $1,000,000 (one million dollar) per Member lifetime maximum Coverage under this Contract for Out-of-Network Benefits.

SECTION VII - REIMBURSEMENT OF EXPENSES FOR TREATMENT BY NON-PARTICIPATING PROVIDERS

A. **Claim Form.**
An itemized bill or, at our discretion, a Claim Form must be submitted to us at the office address set out on the face page of the Contract and the Certificate within ninety (90) days after the date you incur Eligible Expenses. 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 your legal incapacity, shall such bill or claim be reimbursed later than one (1) year from the date on which services were provided or the course of treatment was completed.

B. **Payment of Claims.**

We will pay Eligible Expenses incurred for treatment by a Non-Participating Provider in accordance with this Contract, within a reasonable period of time, upon receipt of the itemized bill or Claim Form. Payment under the Contract may be made, at our discretion, to the Subscriber or Family Dependent who incurs the expense, or directly to the Hospital; person; or entity rendering the service.

C. **Legal Action.**
Subject to exhaustion of the Member Appeal Procedures at Section XV, no action at law or in equity shall be brought to recover under the Contract prior to the expiration of ninety (90) days after submission of the itemized bill or Claim Form and any requested supporting information, nor shall such action be brought after twelve (12) months from the date of completion of a particular course of treatment.

SECTION VIII –GENERAL EXCLUSIONS

IN ADDITION TO CERTAIN EXCLUSIONS AND LIMITATIONS SET FORTH ELSEWHERE IN THIS CONTRACT, THE FOLLOWING ARE NOT COVERED UNDER THIS CONTRACT:

1. Treatment provided in a governmental Hospital; benefits for which you are eligible, whether or nor you are actually enrolled under the Medicare Act including Parts A or B whether or not you have elected to receive Part B coverage (this exclusion shall not apply to (1) Members who are eligible for Medicare by reason of age and who are Covered under this Contract by virtue of the Member's or their spouse's current employment status with an employer group with twenty (20) or more full-time employees, (2) Members who are eligible for Medicare by reason of disability who are under age sixty-five (65) and are Covered under this Contract by virtue of the Member's or a family member's current employment status with an employer who has at least one-hundred (100) employees, or (3) Members who are eligible for or are entitled to Medicare on the basis of end-stage renal disease for the first thirty (30) months of end-stage renal disease based Medicare eligibility to entitlement); benefits for which you are eligible under any other governmental program (except Title XIX of the Social Security Act).

2. Any state or federal workers' compensation, employers' liability or occupational disease law; benefits provided for any loss for which mandatory automobile no-fault benefits are recovered or recoverable including but not limited to benefits which would have been recoverable except for the fact that a timely claim was not filed by you or by a Health Care Provider; services performed by a member of your immediate family.

3. Health Care Services for the treatment of Mental Health Conditions which are not subject to significant improvement and except for acute mental, nervous, or emotional disorders which are susceptible to short-term treatment and pose a serious threat to your mental or physical well being.

4. Any Health Care Services rendered after the Termination of Coverage (Please see Section X); except in the case you are determined to be eligible for benefits under the Continuation of Coverage provision of the Contract (Please see Section XII).

5. Orthotic devices and supplies except as explicitly provided in Section V.D.11.

6. In no case is Coverage provided for replacement or repair of Durable Medical Equipment or prosthetics due to loss or misuse; replacement of parts or supplies used in conjunction with prosthetic and orthotic devices except as explicitly provided in Section V.D.11.

7. Any dental care and treatment including procedures involving teeth or areas surrounding the teeth, orthognathic surgery, including shortening of the mandible or maxillae for correction of malocclusion and all professional, hospital and anesthesia services, except for Medically Necessary dental care and treatment due to Accidental Injury to sound natural teeth occurring within twelve (12) months from the date of the Accidental Injury and dental care and treatment Medically Necessary due to congenital disease or anomaly subject to Deductible and Coinsurance and any additional payments. These services require Precertification under Section IV of this Contract.

8. Temporomandibular disease (TMJ) can be either medical or dental in nature. Coverage for TMJ is excluded when it is dental in nature. Medical care is subject to Deductible and Coinsurance and any additional payments.

9. Any cosmetic procedure or operation, including any further procedures which do not require Medically Necessary services, or any Hospital services connected with a cosmetic operation. A cosmetic operation is Covered 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, including but not limited to, breast reconstruction surgery after a mastectomy and reconstructive surgery because of congenital disease or anomaly of a Covered dependent child which results in a functional impairment. These services require Precertification under Section IV of this Contract for Non-Participating Providers and Preauthorization for Participating Providers.

10. Rhinoplasty, unless Medically Necessary and subject to Preauthorization In-Network and Precertification Out-of-Network under Section IV of this Contract.

11. Reconstructive surgery shall not include surgery for scar repair/revision only, where no physiological functional defect is present unless Medically Necessary.

12. Health Care Services which are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or sickness or to maintain your health. The Contract only Covers Medically Necessary services.

13. 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 your condition, an efficacious procedure that will have no effect on the outcome of your illness, injury or disease are not Covered. Benefits are limited to scientifically established Procedures that have been evaluated by recognized authorities or 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 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 Food and Drug Administration and/or the National Institute of Health Technology Assessment are Covered. We reserve the right to determine Coverage on a case by case basis. Nothing herein shall be interpreted to preclude the application of Insurance Law Section 4303 regarding cancer drugs. The Medical Director shall have the authority to determine issues of Coverage raised under this Paragraph 13. and such determination is final as long as it is neither arbitrary nor capricious. The Medical Director's determination is subject to appeal pursuant to Article 49 of the Insurance Law as set forth in the Member Handbook.

14. The purchasing or fitting of eyeglasses or contact lenses.

15. The expense of purchasing or fitting hearing aids.

16. Services performed by your immediate family including spouse, brother, sister, parent, or child for which, in the absence of any health insurance plan or insurance plan, no charge would be made to you.

17. Physical and mental examinations and immunizations, and drug testing required by third parties in the absence of Medical Necessity for obtaining or maintaining employment or insurance; medical research; travel; school; or camp.

18. Free care or care where no charge, in the absence of the Contract, would be made to you.

19. Any injury or sickness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage of such injury or sickness is provided through any governmental plan or program.

20. Travel and transportation expenses even though prescribed by a physician, except as provided in Section V of the Contract.

21. Benefits otherwise provided in the Contract which we are 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.

22. Long-term Physical Therapy or Long-Term Rehabilitation.

23. Any expense as a result of your failure to vacate a Hospital bed beyond the discharge date established by the Hospital, your physician, and us.

24. Medical equipment; appliances; cosmetics; orthotics; computer assisted communication devices or electronic communication devices which are not incorporated into the body such as air conditions; humidifiers; wigs; cranial prostheses; hair replacements; and athletic equipment even though prescribed by a physician. Not included here is equipment, which would be provided under Section V.D.11.

25. Routine and palliative foot care; including, but not limited to, services or care in connection with any of the following: corns; calluses; flat feet; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet, or orthotics.

26. Custodial care or rest cures and services rendered for the convenience of you or a provider.

27. Court-ordered treatment for Mental Health Conditions and/or Health Care Services unless such treatment is determined to be Medically Necessary.

28. 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.

29. Devices or equipment used solely for the purpose of athletic activities.

30. Health Care Services prescribed by a physician but not Covered by the Contract or Certificate.

31. Eye examinations for glasses or contact lenses.

32. Prescription drugs and medications are excluded except for an inpatient in a Hospital, a Skilled Nursing Facility, Home Health Agency, or for use in the Hospital as an outpatient. Injections and immunizations for Members over age eighteen (18) are excluded except when administered by a physician in his/her office for the purpose of immunization, allergy immunotherapy, diagnostic testing, or occasional brief treatment associated with acute medical conditions. Self-administered injectables are excluded. This exclusion does not apply to diabetic supplies and insulin as provided in Section V.D.15.

33. Any services which were not received in accordance with this Contract, including without limitation, services provided by a Participating or Non-Participating Health Care Provider without appropriate authorization, or when a procedure, treatment, or service is not a Covered health care benefit.

34. Special nurses and attendants or their board, except as allowed under Section V.D.

35. Care for military service connected disabilities, when:

    a. you are legally entitled to services; and

    b. facilities are reasonably available to you.

36. Care for conditions that federal, state or local law requires be treated in a public facility.

37. Services provided for bed rest; custodial care; maintenance care or respite care are not Covered under this Contract and are your responsibility for payment.

38. Any fees for the services of Health Care Providers employed by a Hospital or institution to which a global or case-based payment is made.

39. Eyeglass corrective lenses and frames, contact lenses, services and procedures to correct vision, cranial prostheses, wigs, hair replacements, orthotics – shoe inserts, cosmetic devices, computer-assisted communication devices or electronic communications devices, items such as air conditioners, humidifiers and athletic equipment.

40. Services required by third parties. Examples of non-Covered services are employment physicals, physicals for camp and school, and court-ordered examinations and hospitalizations except when Medically Necessary.

41. Television or phone charges while an inpatient in a Hospital.

42. The following Benefits are not Covered under this Contract:

- Infertility Services except as specifically provided in Section V.D.1.16;
- Reversal of Elective Sterilization:

  Reversal of tubal ligation;

  Reversal of vasectomy;
- All costs associated with the following assisted reproductive technologies: in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian tube transfer (ZIFT). Drugs, self-injectable or otherwise, used in conjunction with any of these procedures are NOT Covered;
- Infertility Services will not be provided to persons who are not our Members;
- Cloning or any services incident to cloning;
- Infertility Services that are deemed to be experimental in accordance with clinical guidelines promulgated by New York State; or
- Sex change procedures.

The above does not exclude Coverage for Medically Necessary medical and surgical care for Diagnosis and treatment of a correctable medical condition, solely because the medical condition results in Infertility.

43. Hearing aid evaluation.

44. Wheelchair van transportation.

45. Services which are not Medically Necessary.

46. Optifast program or other programs with dietary supplements.

47. Expendable medical supplies.

48. Methadone maintenance.

49. Psychometric services which are primarily the responsibility of the education system, such as developmental psychometric testing, special education classes, etc.

50. Clinical laboratory services, pharmacy services, X-ray or imaging services furnished pursuant to a Referral prohibited by Public Health Law Section 238- a (1).

51. Anything except the items of care listed in the Contract.

52. Services for which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.

53. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted. Also, costs related to travel, food or lodging for transplant recipient or donor.

54. The reproduction and furnishing of X-rays and medical records, or any costs associated with the reproduction or furnishing of X-rays and/or medical records.

55. Inpatient substance abuse rehabilitation services.

SECTION IX – ADDITIONAL EXCLUSIONS WHICH APPLY ONLY TO OUT-OF-NETWORK BENEFITS

IN ADDITION TO CERTAIN EXCLUSIONS AND LIMITATIONS SET FORTH ELSEWHERE IN THIS CONTRACT, THE FOLLOWING ARE NOT COVERED OUT-OF-NETWORK UNDER THIS CONTRACT:

1. Prosthetic devices and medical appliances, eyeglass corrective lenses and frames, contact lenses, services and procedures to correct vision, cranial prostheses, wigs, hair replacements, orthotics – shoe inserts, cosmetic devices, computer-assisted communication devices or electronic communications devices, items such as air conditioners, humidifiers and athletic equipment.

2. Primary and preventive care other than as specifically listed in this Contract or Certificate as a Covered service.

3. Inpatient detoxification for substance abuse.

4. Immunizations for Members over age nineteen (19).

5. Any Riders attached to this Contract or Certificate except Riders which specifically indicate that they include services provided by Non-Participating Providers. This exclusion does not apply to Riders which extend Member eligibility.

6. We will not pay for treatment of a Pre-existing Condition for a period of twelve (12) months after the Enrollment Date. For purposes of this section, Enrollment Date means the first day of Coverage of the Member under this Contract or, if earlier, the first day of the waiting period that must pass with respect to such Member before the Member is eligible for Coverage. A Pre-existing Condition is defined as a mental or physical condition, regardless of the cause of the condition, for which medical advice, Diagnosis, care or treatment was recommended or received within the six (6) month period prior to the Enrollment Date. The Pre-existing Condition exclusion period hereunder, shall run concurrently with any waiting period or affiliation period that may apply.

The Pre-existing Condition exclusion under this Section IX shall not apply to the following:

a. Genetic information shall not be treated as a condition described above in the absence of a Diagnosis of the condition related to such information.

b. With respect to an individual who, as of the last day of the thirty (30) day period beginning with the date of birth, is Covered by Creditable Coverage. Creditable Coverage is defined as Coverage of the individual under any of the comprehensive health Coverages, including:

   i. a group health plan;

   ii. health insurance coverage;

   iii. part A or part B of Medicare; or

   iv. Medicaid;

   v. CHAMPUS;

   vi. Indian Health Service or Tribal Benefits;

   vii. State Health Benefits Risk Pool;

viii. Federal Employee Benefit Plan;

ix. Peace Corps.

c. The Creditable Coverage must have Covered the category of benefit for which Coverage is now being sought. For example, if the Member's prior Coverage did not Cover mental health benefits, it shall not be deemed Creditable Coverage for the purpose of applying the Pre-existing Condition exclusion to Coverage for mental health benefits. The categories of Coverage are: mental health, substance abuse and treatment, prescription drugs, dental care and vision care.

d. With respect to a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or placement for adoption is Covered under Creditable Coverage.

e. Pregnancy.

i. In determining whether the Pre-existing Condition exclusion applies to a Member, we shall credit the time the Member was previously Covered by Creditable Coverage, if the previous Coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date. The credit shall apply to the aggregate periods of Creditable Coverage without a break of sixty-three (63) days or more. For purposes of this paragraph, any period shall not be taken into account in determining the continuous period of Coverage unless the Creditable Coverage was health maintenance Coverage.

ii. Pre-existing Condition exclusion shall not apply to an Eligible Person. An Eligible Person is defined as a person who had at least eighteen (18) months of Creditable Coverage, who has taken and exhausted his/her COBRA or other continuation coverages not more than sixty-three (63) days prior to his/her Enrollment Date. An Eligible Person's most recent prior Creditable Coverage must have been under a group health plan, governmental plan or church plan and must not have been terminated for fraud or non-payment of Premiums. In addition, an Eligible Person must not be eligible for Coverage under a group health plan, Medicare or Medicaid.

iii. A Pre-existing Condition exclusion shall not apply to any Member whose Coverage is obtained through a group of three-hundred (300) or more Covered persons, provided that the Member has elected Coverage within thirty (30) days of his/her Eligibility Date.

SECTION X - TERMINATION OF COVERAGE

Your Coverage shall automatically be terminated on the first of the following to apply:

1. Upon the Policyholder's failure to pay the required Premium to us in accordance with Section XVII of the Contract or if Policyholder notifies us prior to the expiration of the grace period that it will no longer pay the Premium.

2. The date that the Contract is terminated, or with respect to any specific Health Care Services Covered by the Contract, the date such Coverage terminates.

3. The end of the Contract Month in which you cease to be eligible as a Subscriber or Family Dependent, or cease to live or work in the Service Area.

4. The date on which the Subscriber ceases full-time employment or membership with the Policyholder.

5. The end of the Contract Month during which the Policyholder receives written notice from you requesting Termination of Coverage, or on such later date requested for such termination by the notice.

6. The date on which the Subscriber is retired or pensioned, unless Coverage is specifically provided for retired or pensioned individuals in the Policyholder's application attached to the Contract.

7. Death of a Subscriber or the Divorce from Subscriber – Upon the death of the Subscriber, or a divorce from a Subscriber, this Contract shall automatically terminate as of the date of death or the date of the divorce decree. (For Conversion/Continuation Rights of Group Coverage with respect to any surviving Members, see Sections XI and XII).

8. You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract. We shall give the Policyholder at least one month's prior written notice.

9. Discontinuance of the class of contract to which this Contract belongs. In the event this Contract is terminated for this reason, we will give the Policyholder at least ninety (90) days prior notice. (For Conversion/Continuation Rights of Group Coverage, see Sections XI and XII).

10. Such other reasons as the Superintendent of Insurance may approve consistent with applicable law. We shall give the Policyholder at least one month's prior notice.

11. Notice. Except as otherwise provided herein, we shall give the Subscriber and the Group at least thirty (30) days prior written notice of any termination or refusal to renew under this Section X.

12. Change in Status under Family Unit. If you are no longer Covered under this Contract because you are no longer within the definition of Primary or Family Unit, your eligibility for benefits under this contract shall terminate automatically and without notice. (For Conversion/Continuation Rights of Group Coverage, see Sections XI and XII).

13. No Benefits after termination, non-renewal, or modification upon annual renewal. Upon termination for any reason, non-renewal, or modification upon annual renewal, the Member shall cease to be entitled to any Benefits, including but not limited to, lifetime benefits, unlimited benefits or benefits provided to the Member who is, at the time of termination, non-renewal or modification upon annual renewal, undergoing a course of treatment. Hospital or SNF Benefits shall be extended for a Member who is hospitalized or in a SNF at the time of termination or non-renewal. Payment will be for the Hospital or SNF charges for that particular confinement unless the Member has obtained other health care Coverage, in which case such other Coverage shall apply. This extension of benefits after termination or non-renewal only applies to Hospital and SNF services; physician and other services are not Covered.

14. Benefits will be provided after termination for persons who have a Total Disability on the date Coverage terminates if service or care was received for the illness, condition or injury which caused the Total Disability while Covered under this Contract, until the person no longer has a Total Disability or twelve (12) months from the date Coverage terminates, whichever occurs first, unless Coverage is afforded for Total Disability under another Group Benefit Plan.

SECTION XI - CONVERSION PRIVILEGE

You are eligible to convert to the Direct Payment Contract which is most nearly comparable to the benefits being offered by us under this Contract; effective as of the date of termination of your group Coverage, upon submitting an Application Form within the required time and payment of the applicable quarterly or; at your option, insurability if the Application Form is mailed or delivered to our office within forty-five (45) days of the date that you first become 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 Policyholder.

2. The termination of your eligibility, regardless of the time period you were Covered, by reason of:

   a. reaching the maximum age set out in the Contract and/or any Riders attached to it where you can no longer be considered an eligible Family Dependent;

   b. death of the Subscriber;

   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 Policyholder has replaced the group Contract with similar and continuous Coverage for the same group whether insured or self-insured.

   You shall be eligible to obtain and continue your Direct Payment Agreement only as long as you are not covered by, or eligible for coverage by, another substantially similar insurance policy; prepaid plan; or other health benefit plan or program offered by any party including the federal; state; or local government, which together with the Direct Payment Agreement would result in over insurance or duplication of benefits according to the standards on file with the Superintendent of Insurance. The Direct Payment Agreement Coverage is not available if you are eligible for Medicare by reason of age. The Policyholder agrees to notify you of the right to convert to a Direct Payment Agreement upon termination of a Subscriber's employment or Membership in the group.

   The Policyholder agrees to pay any additional administrative expenses incurred by us if it fails to provide the notice as provided in this paragraph and the Subscriber converts to a Direct Payment Agreement 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 XII – CONTINUATION OF COVERAGE

1. If the Subscriber's Coverage under the Contract ends due to termination of employment or Membership in the group, he or she may continue Coverage at a monthly Premium no more than 102% of the group rate. 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 an alternative health benefits plan, which provides group health coverage, pursuant to Section 4305(e)(1) of the Insurance Law.

2. Under certain circumstances, a Member may be entitled to a continuation of group health coverage under federal COBRA law. IHBC is not the Plan administrator under COBRA. COBRA continuation coverage applies to groups with twenty (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 sixty (60) days following the latter of the date of termination of employment or the date the Member is given notice of the right to continuation by the Policyholder.

   Continuation of Coverage under New York law shall terminate on the date eighteen (18) months after the date of the Subscriber's termination from employment. In the case of an eligible Family Dependent of the Subscriber, Continuation of Coverage shall terminate on a date thirty-six (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 ceases to be a dependent child under the requirements of the Contract.

In the case of a Subscriber who is determined to be disabled at the time of termination of employment pursuant to Medicare law, continuation of Coverage shall terminate twenty-nine (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. Future monthly Premium payments must be made in advance to the Policyholder. Any questions regarding continuation rights should be directed to the Policyholder or us.

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. This will apply if Premiums are not paid on time; or

   c. The date on which the Contract is terminated.

4. The Conversion Privilege described in Section XI is available when any period of Continuation of Benefits under this section ends.

SECTION XIII - COORDINATION OF BENEFITS

A. If you are eligible for services or benefits under two or more Group Benefit Plans; providing or paying for Health Care Services rendered to you, the Coverage under those Group Benefit Plans will be coordinated so that up to, but no more than, 100% of any of our Eligible Expenses will be paid for; or provided by, all the benefit plans less any Copayments or Deductible and Coinsurance. When we have paid up to our Fee Schedule or you have received from other payment sources up to our Fee Schedule, no further payment will be made. We will be responsible, as either a primary or secondary payor, for Health Care Services rendered by Participating Providers; Medical Emergency care; or the services of Non-Participating Providers and as a secondary payor for any item of Allowable Expense as required by the Insurance Department's regulations. The term "Allowable Expense" is the necessary; reasonable; and customary item of expense for Covered health care. 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;

   d. 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.

B. We shall be entitled to:

1. Determine whether and to what extent you have indemnity or other Coverage for the Health Care Services provided under the Contract;

2. Establish priorities for primary responsibility among the Health Plans obligated to provide Health Care Services or indemnity benefits;

3. Release to or obtain from any other Health Plan any information needed to implement this provision; and

4. Recover the value of Health Care Services rendered to the Member under the Contract to the extent that such Health Care Services are covered by any other Health Plan with primary responsibility for paying for such Health Care Services.

C. When our Coverage is the primary Coverage, it will pay for all necessary Health Care Services in accordance with the Contract. The secondary health plan may be obligated to pay any Coinsurance; Copayment; or other charges not Covered by us if you file a claim with that group health plan. When our Coverage is secondary, we reserve the right to request that you submit claims to the other group health plan; recover any claim payment that you receive 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 Care Services provided or paid for by us.

D. For purposes of this Section, "other plans" include: Group or blanket coverage; Blue Cross, Blue Shield, or other prepayment coverage; no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; coverage under a labor-management trustee plan, union welfare plan, or an employee welfare benefit plan as defined in the Federal Welfare and Pension Plan Disclosure Act, including any federal or state or other governmental plan or law; or coverage under any plan largely or solely tax supported or otherwise provided by or through action of any government, except Medicaid.

SECTION XIV - RECOVERY OF PAID EXPENSES/RIGHT OF SUBROGATION

You understand and agree to the following provisions regarding our right to recovery of paid expenses and right of subrogation.

1. When you receive reimbursement for identified Hospital, medical, and/or health care expenses as a result of court action, judgment, settlement or payments from liability coverage of any party and/or any other reimbursement method, then you shall reimburse us for such expenses that we pay on your behalf; and we shall have a lien upon such judgment, settlement, payment or other reimbursement to the extent we have paid your expenses.

2. This paragraph applies when another party is, or may be considered liable, for your injury, sickness or other condition (including insurance carriers who are so liable) and we have provided or paid for benefits.

    a. We are subrogated to all of your rights against any party liable for your injury, illness or condition or for the payment for Hospital, medical, and/or health care services in treatment of such injury, illness or condition (including any insurance carrier), to the extent of the reasonable value of the Hospital, medical, and/or health care benefits paid for or provided by us to you. We may assert this right independently of you.

    b. You are obligated to cooperate with us and our agents in order to protect our subrogation rights. Cooperation means providing us or our agents with any relevant information requested by them, signing and delivering such documents as we or our agents reasonably request to secure our subrogation claim, and obtaining the express written consent of us or our agents before releasing any party from liability for payment of Hospital, medical, and/or health care expense.

    c. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must provide notice to us and may not prejudice, in any way, our subrogation rights under this Section.

    d. Our costs of legal representation in matters related to subrogation shall be borne solely by us. Your costs of legal representation shall be borne solely by you.

SECTION XV - APPEAL PROCEDURES

A. You have the right to file a complaint or appeal regarding any dispute you may have with us. You can file a verbal or written quality complaint, contractual appeal or clinical appeal regarding a pre-service denial (a request to change a denial for any care of services that have not yet been provided to you) or a post-service denial (a request to change a denial for care or service already rendered) by contacting the Member Services department during normal business hours, at least forty (40) hours per week. When filing an appeal, you have the opportunity to submit any written documents or other information relating to their appeal. See the Member Handbook for the process on how to initiate appeals or grievances.

SECTION XVI - RELATIONSHIP BETWEEN PARTIES

The relationship between us and Participating Providers is a contractual relationship between independent contractors. Participating Providers are not agents or employees of ours, nor are we or any employee of ours an agent or employee of Participating Providers.

The relationship between a Participating or Non-Participating Physician and you is that of a physician and patient. The Participating or Non-Participating Physician is solely responsible for the Health Care Services to you. We are not liable for any act; omission; or other conduct of any provider in furnishing professional; ambulatory; Hospital or any other services to you; nor is any Participating or Non-Participating Provider liable for the acts of any other provider based solely upon his or its association with us.

SECTION XVII - CONTRACT PROVISIONS

A. Premium Payment-Computation.
All Premiums are payable monthly in advance by the Policyholder to us at our office indicated on the face page of the Contract. The Policyholder will arrange to collect any applicable Subscriber contributions for the Premium directly from the Subscriber. The Policyholder shall pay the total monthly Premium due us on behalf of those Subscribers on or before the first day of any month during which Coverage is to be provided to Subscribers. The first Premiums are due and payable on the Effective Date of the Contract. Subsequent Premiums are due and payable on the first of each Contract Month thereafter during the continuance of the Contract. The Policyholder

shall act as the agent for the group's Subscriber and shall not, under any circumstances, be the agent; employee; or representative of ours in collecting any amounts from such Subscriber and paying it to us.

The initial Premium for Coverage is set forth on the Contract. We will provide the Policyholder with at least thirty (30) days notice of the Effective Date of any Premium increase or decrease approved by the State of New York.

When you and/or Policyholder have entered into an agreement with us for a "Fixed Premium Rate with Recoupment," the following shall apply:

1. The "Fixed Premium Rate" means a level Premium rate which does not change for an agreed upon period of time.

2. However, if during any Contract Year there shall have been a change in the Premium rate, then you and/or Policyholder shall be liable for any increase in Premium rate retroactive to the Effective Date of the approved increase.

3. Payment of the difference between the Fixed Premium Rate and the increase shall not be made until the end of the Fixed Premium Rate period.

4. We will pro-rate any Premium increase over the next one-year period if group Coverage continues. If Policyholder terminates our Coverage, the prior period Premium rate increase shall immediately become due and payable to us.

We shall calculate the Premium based upon our records of the number and Coverage of Members as of the fifteenth (15th) day of the month preceding the date that the next month's Premium is due and payable. The Policyholder shall provide us by the fifteenth (15th) day of the month preceding the date that the next month's Premium is due and payable with a list of deletions or additions of any Members to be Covered or not to be Covered by us. We shall send the Policyholder its invoice for the following month by the twentieth (20th) day of the preceding month.

We and the Policyholder shall cooperate to complete any retroactive adjustments to the Premium necessary as a result of the addition or termination of Members Covered by us. We shall not be required to make a retroactive adjustment if the Policyholder fails to notify us of the addition or termination of a Member's Coverage, effective as of the first day of the month; by or before the fifteenth (15th) day of the same month. If a Member is added or terminated to the group Covered under the Policyholder's Contract during the period from the first (1st) to the fifteenth (15th) day of any month, the Premium will be retroactively adjusted as of the first (1st) day of the month.

The Premium will not be adjusted if a Member's Coverage terminates or becomes effective between the fifteenth (15th) and the last day of any month. If the Policyholder does not notify us of the termination of a Member's Coverage as of the first (1st) day of a month, by the first (1st) day of that month, and the Member receives any Health Care Services between the first (1st) day of said month and the date that the Policyholder provides us with such notice; the Policyholder shall not be entitled to any retroactive adjustment of Premium based upon the termination of that Member's Coverage.

B. Grace Period.

A grace period of ten (10) days will be granted for the payment of any Premium during the time the Contract shall continue in force. If the Premium is not paid within that ten (10) day period, the Coverage of all Members Covered by the Contract will be deemed to have terminated automatically as of the last date for which Premium payments have been made, without notice from us to the Policyholder or to the Members. We shall be entitled to notify Subscribers of the non-payment of Premium and the expiration date of the grace period provided by this provision to enable them to make necessary arrangements to pay for their Health Care Services upon termination of the Contract. The termination of the Contract upon expiration of the grace period shall not relieve the Policyholder of its obligation to pay Premium due for Coverage provided.

Upon termination of the Contract, the Policyholder shall be liable to us for the payment of any and all Premiums, which are due but unpaid at the time of termination.

SECTION XVIII - GENERAL PROVISIONS

A. Entire Contract.

The Contract, the application of the Policyholder, your individual Application Form, and our policies and procedures as adopted or amended from time to time, shall constitute the entire Contract between the parties. All statements made by the Policyholder or by you 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 Policyholder and/or you.

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 (2) years.

C. Alteration.

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

D. Consent to Release & Use of Health Information.

1. You consent to the release of all health information to us for you and your other enrolled Family Dependents when you become Covered under this Certificate. You also and consent to our using and disclosing your health information for our payment and health care operations activities and for another Health Care Provider or institution's treatment, payment and health care operations activities. Such uses and disclosures shall be made in accordance with applicable laws, rules and regulations.

2. Unless otherwise prohibited by law, you give implied consent to release health information upon presenting your Membership Card to any Health Care Provider.

3. We shall have the right to deny Health Care Services or to refuse reimbursement for Health Care Services to any Member who refuses to consent to the release of health information.

4. You agree to execute any releases for health information which we request of you at no charge to us.

5. This consent to release of health information is subject to the provisions of the New York Public Health Law, Section 18 and 4410(2), unless otherwise preempted by applicable federal laws, rules and regulations.

E. Forms.

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

F. Records.

1. The Policyholder shall furnish us with all information and proofs, which we may reasonably require with regard to any matters pertaining to the Contract. All documents furnished by the Policyholder and any other records which may have a bearing on the Coverage under the Contract shall be open for inspection by us at any reasonable time and shall be kept confidential by us in accordance with applicable laws, rules and regulations.

2. You authorize and direct any person or institution that has examined or treated you to furnish us at any and all reasonable time, upon our request; any or all information and records or copies of records relating to the examination or treatment rendered to you. We shall have the right to submit any and all records concerning Health Care Services rendered you to appropriate medical review personnel.

3. In the event of a question or dispute concerning the provision of Health Care Services or payment for such services under the Contract, we may reasonably require that you be examined, at our expense, by a Participating Physician designated by us.

G. Notice.

1. All notices to the parties to the Contract shall be in writing; postage prepaid; first class mail; and shall be deemed given when mailed. The notices shall be mailed to the two parties indicated on the title page or to such other address or person designated by either party, in writing, during the term of the Contract.

2. Notice given by us to an authorized representative of the Policyholder 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 Policyholder agrees to provide appropriate notice to all affected Subscribers at its own expense.

H. Covered Benefits.

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

I. Membership Certificate.

We will issue to the Subscriber a Membership Certificate describing the Health Care Services to which he or 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 or Law.

L. Pronouns.

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

M. Conformity with Statutes/Venue.

The Contract shall be governed by the Laws of the State of New York and venue for any dispute shall be in Erie County, New York.

N. Events Beyond Our Control.

In the event of circumstances not reasonably within our control (such as complete or partial destruction of health care facilities; war; riot; civil insurrection; or similar causes), we shall not be responsible for the performance of its obligations under this Contract provided however that we shall resume performance of its obligations under this Contract as soon as reasonably possible.

O. 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.

P. Interpretation.

We 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 Policyholder and you upon reasonable notification to you.

SECTION XIX - EXTERNAL APPEAL

1. Your Right to an External Appeal. Under certain circumstances, you have a right to an external appeal of a denial of Coverage. Specifically, if we have denied Coverage on the basis that the service is not Medically Necessary or is

an experimental or investigational treatment, you, or you representative may appeal that decision to an external appeal agent, an independent entity certified by the state to conduct such appeals.

2. Your Right to Appeal a Determination That a Service is Not Medically Necessary. If we have denied Coverage on the basis that the service is not Medically Necessary, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

   a. The service, procedure or treatment must otherwise be a Covered service under this Contract; and

   b. You must have received a final adverse determination through the first level of our internal appeal process (i.e. the member complaint and appeal process) and we must have upheld the denial **or** you and us must agree in writing to waive any internal appeal.

3. Your Rights to Appeal a Determination That a Service is Experimental or Investigational. If you have been denied Coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

   a. The service must otherwise be a Covered service under this Contract; and

   b. You must have received a final adverse determination through the first level of our internal appeal process (i.e. the member complaint and appeal process) and we must have upheld the denial **or** you and us must agree in writing to waive any internal appeal.

   In addition, your Attending Physician must certify that you have a Life Threatening or Disabling Condition or disease. A "Life-Threatening Condition or Disease" is one, which, according to the current Diagnosis of your Attending Physician, has a high probability of death. A "Disabling Condition or Disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen (18), a "Disabling Condition or Disease" is any medically determinable physical or mental impairment of comparable severity.

   Your Attending Physician must also certify that your Life-Threatening or Disabling Condition or Disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure Covered by us **or** one for which there exists a clinical trial (as defined by law).

   In addition, your Attending Physician must have recommended one of the following:

   a.1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered service (only certain documents will be considered in support of this recommendation – your Attending Physician should contact the state in order to obtain current information as to what documents will be considered acceptable); or

   b.1. A clinical trial for which you are eligible (only certain clinical trials can be considered).

   For the purposes of this section, your Attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

4. The External Appeal Process. If, through the first level of our internal appeal process (i.e. the member complaint and appeal process), you have received a final adverse determination upholding a denial of Coverage on the basis that the service is not Medically Necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and we have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal.

You may also request an external appeal application from New York State Department of Insurance at 1-800-400-8882 or 1-518-486-7815 or its website (www.ins.state.ny.us). Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the state will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information submitted represents a material change from the information on which we based its denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below); we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your Attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not Medically Necessary or approves Coverage of an experimental or investigational treatment, we will provide Coverage subject to the other terms and conditions of this Contract. Please note that if the external appeal agent approves Coverage of an experimental or investigational treatment that is part of a clinical trial, we will only Cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Contract for non-experimental or non-investigational treatments provided in such clinical trial.

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

We will charge you $50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. We will also waive the fee if we determine that paying the fee would pose a hardship to you. If the external appeal agent overturns the denial of Coverage, the fee shall be returned to you.

5. Your Responsibilities. **It is YOUR RESPONSIBILITY to initiate the external appeal process.** You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from us that we have upheld a denial of Coverage or the date upon which you receive a written waiver of any internal appeal. We have no authority to grant an extension of this deadline.

Independent Health℠ | 511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 027
INPATIENT REHABILITATION FOR SUBSTANCE ABUSE

Issued by
Independent Health Benefits Corporation

This Rider increases Coverage under your Group Health Contract or Certificate (GHC). You are entitled to receive inpatient rehabilitation services in accordance with the terms of the GHC and as stated below:

SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Inpatient Rehabilitation. Up to thirty (30) days per Calendar Year for diagnosis and treatment of chemical dependency, which for purposes of this Rider shall mean alcoholism; alcohol abuse; and substance abuse. a. Services must be provided in: Facilities in New York State which are certified by the Division of Alcoholism and Alcohol Abuse or the Division of 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 services must be provided pursuant to a treatment plan, which has been submitted by the facility to us within ten (10) days of the first treatment and approved in writing by the Medical Director. Services rendered after the initial ten (10) day period will not be Covered without Medical Director approval of the treatment plan. c. Persons whose primary	Services will be subject to the applicable inpatient Hospital Copayment, if any, in the Member's GHC. Refer to the Inpatient Hospital Services benefit in the GHC for both the amount and frequency of the inpatient Copayment. These services require Preauthorization under this Contract.	Not Covered.

Diagnosis is alcohol abuse or alcoholism may be treated only in a facility certified to treat such Diagnoses. d. Persons whose primary Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnoses. e. Care must be as a result of alcohol dependence or substance dependence. f. Treatment of associated health conditions will be Covered under basic Health Care Services of the GHC.		

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: _____

President

Independent Health℠ | 511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 502
AGE EXTENSION (25) FULL-TIME STUDENT

Issued by
Independent Health Benefits Corporation

This is a Rider to your Group Health Contract or Certificate (GHC) which extends Coverage for Family Dependents who are:

Unmarried children over nineteen (19) years of age, but not yet reaching twenty-five (25) years of age. These children must be enrolled in an accredited college or university on a Full-Time basis. "Full-Time" means twelve (12) credit hours per semester.

Coverage under this Rider terminates at the earlier of the end of the month in which the child turns twenty-five (25) years of age, or when the child ceases to be enrolled on a Full-Time basis in an accredited college or university, except as provided herein.

Coverage for a child, who was a Full-Time student until taking a leave of absence from school due to illness, shall be extended for a period of twelve (12) months from the last date of attendance in school or until the child's Coverage would otherwise terminate under the GHC as amended by this age extension Rider, whichever is sooner. To receive Coverage, the Medical Necessity of a leave of absence must be certified by a physician licensed to practice in the State of New York and submitted in writing to Independent Health Benefits Corporation.

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: Frank Colantuono
Chairman

Independent Health
511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 505
DOMESTIC PARTNER

Issued by
Independent Health Benefits Corporation

This is a Rider to your Group Health Contract or Certificate (GHC) to include as a Family Dependent the following:

The Subscriber's domestic partner who meets all of the following:

a. Of the same or opposite sex; and
b. At least eighteen (18) years of age; and
c. Not related by marriage or by blood in a way that would bar marriage; and
d. Not married to anyone else nor have had another domestic partner for a period of not less than one (1) year; and
e. Registered as the Subscriber's domestic partner; and
f. Provides proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
g. Provides evidence of two or more of the following:
    1. a joint bank account;
    2. a joint credit or charge card;
    3. joint obligation on a loan;
    4. status as authorized signatory on the Subscriber's bank account, credit card or charge card;
    5. joint ownership of residence;
    6. joint ownership of real estate other than residence;
    7. listing of both partners as tenants on a lease of the shared residence;
    8. shared rental payments of residence (need not be shared 50/50);
    9. listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    10. a common household and shared household expenses, (e.g., grocery bills, utility bills, telephone bills, etc.);
    11. shared household budget for purposes of receiving government benefits;
    12. status of one as representative payee for the other's government benefits;
    13. joint ownership of major items of personal property (e.g., appliances, furniture);
    14. joint ownership of a motor vehicle;
    15. joint responsibility for child care;
    16. shared child-care expenses;
    17. execution of wills naming each other as executor and/or beneficiary;
    18. designation as beneficiary under the other's life insurance policy;
    19. mutual grant of durable power of attorney;
    20. mutual grant of authority to make health care decisions (e.g., health care power of attorney);
    21. affidavit by creditor or other individual able to testify to partners' financial interdependence;
    22. other items of proof to establish economic interdependency under the circumstances of the particular case.

In order to enroll the Subscriber's domestic partner, the Subscriber must execute a Domestic Partner Affidavit and pay us the additional Premium, if any, within thirty (30) days of the Subscriber's Eligibility

Date, during the Policyholder's Open Enrollment Period or during a Special Enrollment period as defined in the GHC.

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: _____

Chairman

Independent Health

511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 506
DEPENDENT AGE EXTENSION
UP TO END OF CALENDAR YEAR

Issued by
Independent Health Benefits Corporation

This is a Rider to your Group Health Contract or Certificate (GHC) and/or other age extension Rider which is attached.

Any children who qualify as Family Dependents are Covered up to the end of the Calendar Year in which they reach the age at which they would lose eligibility under the terms of the attached GHC and/or age extension Rider.

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: Frank Columbus
Chairman

Independent Health | 511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 049
DIFFERENTIAL COPAYMENT RIDER

Issued by
Independent Health Benefits Corporation

This is a Rider to your Group Health Contract or Certificate (GHC).

This Rider changes the In-Network Copayment for services rendered by Primary and Specialty Health Care Providers (HCP) as follows:

I. Replace the following paragraphs in **SECTION V.D. – SCHEDULE OF COVERAGE** with the following:

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.1	Office Services subject to a Copayment for each visit to the office of the Health Care Provider.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.2	Home Visits not including Home Health Care Providers and Home Infusion Therapy as provided in Section V.D.9.1.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.6	Periodic Routine Health Examinations. Services must be provided by your Primary HCP of record or by a Specialty HCP upon Referral.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.11	Allergy Tests and Allergy Injections. If arranged by the allergist, allergy injections may be delivered at your Primary HCP's office, subject to the applicable Copayment for your Primary HCP.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.12	Hearing Examinations ordered by a Physician.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK

1.13	Surgical Procedures when performed in the office.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.14	Immunizations for Members over age nineteen (19). If the only office service is for an Influenza or Pneumonia immunization, there is no Copayment.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Not Covered.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
1.15	Surgical Care and Anesthesia.	Primary HCP: $15 Copayment. Anesthesia: Covered in Full.	Specialty HCP: $25 Copayment. Anesthesia: Covered in Full.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
1.18	Chemotherapy.	$25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
4.3	Outpatient Services subject to a Copayment for each visit to the Hospital.	$25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
4.4	Chemotherapy.	$25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
4.7	Pulmonary Rehabilitation: Twenty-four (24) visits per Calendar Year. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$25 Copayment. These services require Preauthorization under this Contract.	These services require Precertification under Section IV of this Contract. If Precertified, such services will be Covered subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK

4.8	Dialysis Services.	$25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
7.2	Outpatient services. Up to sixty (60) visits per Calendar Year for Diagnosis and treatment of alcoholism; alcohol abuse; and substance abuse. On a family policy, up to twenty (20) of the sixty (60) visits may be used for family therapy related to alcoholism; alcohol abuse; or substance abuse by a Covered Family Member. In-Network Services plus Out-of-Network Services combined equals the total benefit. Limitations: a. Services must be provided in: Facilities in New York State which are certified by the Division of Alcoholism and Alcohol Abuse or the Division of 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 services must be provided pursuant to a treatment plan, which has been submitted by the facility to us within ten (10) days of the first treatment and approved in writing by the Medical Director. Services rendered after the initial ten (10) day period will not be Covered without Medical Director approval of the treatment plan. c. Persons whose primary Diagnosis is alcohol abuse or alcoholism may be treated	$25 Copayment. These services require Preauthorization under this Contract.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	only in a facility certified to treat such Diagnoses. d. Persons whose primary Diagnosis is substance abuse or substance dependence may be treated only in a program approved to treat such Diagnoses. e. Care must be as a result of alcohol dependence or substance dependence. f. Treatment of associated health conditions will be Covered under basic Health Care Services of the Contract.		

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
10.1	Second Surgical Opinions.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
16.1	Medically Necessary Chiropractic Care: Coverage will be provided for care by a licensed chiropractor for the purpose of removing nerve interference and the effects thereof which are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column, when determined to be a Medically Necessary service by the Medical Director. This care must be provided in connection with the detection or correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body.	$25 Copayment. The Health Care Provider must obtain Preauthorization prior to treating the Member; however, the Member will not be held responsible if the Health Care Provider renders treatment without Preauthorization.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
17.1	Second Medical Opinions	Primary HCP:	Specialty HCP:	Subject to Deductibles,

	Regarding Cancer: A Member who receives a positive or negative Diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer is entitled to a second medical opinion by an appropriate Specialty Physician, including but not limited to a Specialty Physician affiliated with a specialty care center for the treatment of cancer.	$15 Copayment.	$25 Copayment.	Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK		OUT-OF-NETWORK
18.1	Diagnostic screening for prostate cancer. Coverage for standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen (PSA) test is available to men who are any age having a prior history of prostate cancer. Coverage for annual standard diagnostic examination including, but not limited to, a digital rectal examination and prostate specific antigen test is available for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over having family history of prostate cancer or other prostate cancer risk factors.	Primary HCP: $15 Copayment.	Specialty HCP: $25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

	SERVICE OR BENEFIT	IN-NETWORK	OUT-OF-NETWORK
20.1	Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to thirty-six (36) visits per event. In-Network Services plus Out-of-Network Services combined equals the total benefit.	$25 Copayment.	Subject to Deductibles, Coinsurance and additional payments set forth in Section V.C. of this Contract.

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: _____

President

Independent Health
511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

RIDER 014
$10/$20/$35 THREE-TIERED PRESCRIPTION

Issued by
Independent Health Benefits Corporation

This is a Rider to your Group Health Contract or Certificate (GHC). Delete the exclusion for prescription drugs. This Rider provides the following additional Coverage to your Group Health Contract or Certificate (GHC):

"Up to a thirty (30) day supply, in most instances, of Medically Necessary prescription drugs including enteral formulas for home use. Enteral formulas are only Covered if the Member has an order from a duly licensed physician or other Health Care Provider. The order must state that the enteral formula is Medically Necessary and proven effective as a disease specific treatment for any of the following diseases:

Phenylketonuria (PKU);
Inherited diseases of amino acid or organic acid metabolism;
Crohn's Disease;
Gastroesophageal reflux with failure to thrive;
Gastrointestinal disorders such as chronic intestinal pseudo-obstruction;
Multiple, severe food allergies; or
Any other disease which, without the specified enteral formula, would cause malnourishment, chronic physical disability, mental retardation or death.

Enteral formulas include modified solid food products that are low protein or which contain modified protein.

This Rider Covers prescription drugs approved by the Federal Food and Drug Administration for the diagnosis and treatment of Infertility ("Infertility Drugs"), which are prescribed to an eligible Member who meets the definition of Infertility as set forth under the Member's Group Plan Certificate or Contract and is at least twenty-one (21) years old and no older than forty-four (44). All prescriptions for Infertility Drugs must be specifically Preauthorized and must be prescribed pursuant to a treatment plan which has been submitted in advance to us. Infertility Drugs (self-injectable or otherwise) related to the following procedures are NOT Covered:

Reversal of Elective Sterilization:

Reversal of tubal ligation;
Reversal of vasectomy;

In vitro fertilization (IVF);
Gamete intrafallopian tube transfer (GIFT);
Zygote intrafallopian tube transfer (ZIFT);

Cloning or any services incident to cloning;
Infertility Services that are deemed to be experimental in accordance with clinical guidelines promulgated by New York State;
Sex change procedures.

All prescriptions must be filled using FDA approved generic equivalents if available. All other prescriptions must be filled using FDA approved brand name pharmaceuticals. Drugs must be prescribed by a duly licensed physician or other Health Care Provider who is licensed to write prescriptions. Enteral formulas must be prescribed by a physician or other licensed Health Care Provider. Drugs must also be obtained at a Participating Pharmacy. Prescription drugs obtained at a Non-Participating Pharmacy are not Covered. Certain injectable and high cost specialty prescriptions must be filled through a specific Participating Pharmacy which specializes in these drugs. These drugs are identified in the Formulary.

The amount that the Member will have to pay depends on whether the prescription is filled with a drug that appears on the Formulary. A Formulary is a list of appropriate and cost-effective medications from which physicians prescribe. The Member may obtain a Formulary upon request or from our website at www.independenthealth.com.

Except as provided below, when dispensed in accordance with Independent Health's Drug Formulary, the Member is responsible for a $10 Copayment for Formulary Tier 1 drugs, and a $20 Copayment for Formulary Tier 2 drugs. The Member is response for a $35 Copayment for Tier 3 drugs.

Coverage of prescribed drugs for certain types of cancer shall not exclude Coverage of a prescribed drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, provided however that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following: (i) American Medical Association Drug Evaluations, (ii) American Hospital Formulary Service Drug Information, or (iii) United States Pharmacopeia Drug Information, or recommended by a review article or editorial comment in a major peer-reviewed professional journal. Notwithstanding the above, there is no Coverage for any experimental or investigational drugs unless directed by an external appeal agent or any drug which the FDA has determined to be contra-indicated for treatment of the specific type of cancer for which the drug has been prescribed.

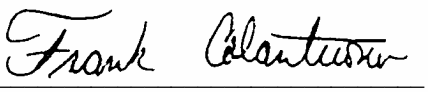
Certain drugs must have written pre-approval by the Medical Director."

This Rider does not include nicotine replacement therapy (nicorette gum or nicotine patches), weight loss medications, cosmetic medications, or enteral formulas which are not Medically Necessary and/or taken electively. Coverage for modified solid food products shall not exceed $2,500 per Member per Calendar Year.

Coverage under this Rider is subject to all the exclusions in your GHC.

All of the terms, conditions and limitations of the Certificate or Contract to which this Rider is attached shall remain in full force and effect and shall apply to this Rider except where specifically changed by this Rider.

INDPENDENT HEALTH BENEFITS CORPORATION

BY: 

Chairman