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

CITIGROUP INC.
GROUP HEALTH CONTRACT

Issued by
INDEPENDENT HEALTH BENEFITS CORPORATION

President,
Independent Health Benefits Corporation

GROUP HEALTH CONTRACT
SECTION 1: INTRODUCTION

Independent Health Benefits Corporation ("Independent Health" 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 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 Family 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.

This Contract consists of eight (8) sections issued together. These sections are:

Section 1: Introduction

Section 2: Definitions

Section 3: Eligibility, Enrollment and Conditions of Coverage

Section 4: Benefit Endorsement and Schedule of Coverage

Section 5: Limitations of Coverage and Exclusions

Section 6: Claim Filing and Coordination of Benefits

Section 7: Termination, Conversion and Continuation of Coverage

Section 8: General Provisions

Any future changes shall result in the affected section(s) being amended or reissued.

All Coverage under the Contract shall begin and end at 12:01 a.m., Eastern Standard Time on the day indicated in the Rate/Remittance Endorsement issued to the Policyholder.

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 President 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.

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 2: DEFINITIONS

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

2. **Allowable Expense**: the necessary, reasonable and customary item of expense for Covered health care.

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.

6. **Calendar Year**: is a twelve-month period beginning January 1 and ending 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 you to submit claims for treatment by Health Care Providers.

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

11. **Continuous Confinement**: consecutive days of Hospital and/or skilled nursing facility service received as an inpatient, or successive confinements when discharge from and readmission to a Hospital/skilled nursing facility occur within a period of time not more than ninety (90) days. A confinement for an accident shall not be combined with another confinement for an illness in determining Continuous Confinement.

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

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

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

15. **Copayment**: a charge, in addition to the Premium, which you are required to pay for certain Health Care Services provided under the Contract. It is usually expressed as a fixed dollar amount or a percentage 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 Health Care Services are provided.

16. **Coverage or Covered**: the Health Care Services and items reimbursed under the Contract.

17. **Designated Physician**: 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 Out of Plan Authorization to a Designated Physician must be given in advance by our Medical Director. Authorization in advance is not required in a Medical Emergency.

18. **Deductible**: where applicable, an amount payable by or on behalf of you for Covered Health Care Services rendered by a Health Care Provider in a Contract Year. Any amounts paid for Copayment or Coinsurance shall not count toward the Deductible. The Deductible is determined as of the date(s) claims are processed by us, not the date that services were rendered.

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

20. **Direct Payment Agreement**: a Contract issued by us directly to the Member, in accordance with the Conversion Privilege described by Section 7 of the Contract, or for any other reason, which requires the Member to pay the Premium directly to us for that Contract.

21. **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.

22. **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 Pemium 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 Family 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.

23. **Family Coverage**: Coverage for which Premiums have been paid to Cover the Subscriber and one or more Family Dependents.

24. **Family Dependent(s)**: a person meeting all the eligibility requirements set forth in Section 3.

25. **First Degree Relative**: 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 or entity who is licensed, certified or otherwise qualified under a state's laws to provide the Health Care Services available under this Contract. All Health Care Providers are independent entities and are not employees or agents of Independent Health.

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. **Independent Health**: means Independent Health Benefits Corporation, a non-profit corporation licensed under Article 43 of the Insurance Law of the State of New York.

30. **Individual Coverage**: Coverage for which Premiums have been paid to Cover the Subscriber only.

31. **Medicaid**: Title XIX of the Social Security Act, as amended from time to time.

32. **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.

33. **Medically Necessary**: any Covered Health Care Services that are required to preserve and maintain the Member's health and to diagnose, treat or prevent disease or injury, alleviate symptoms of an illness or disorder, are consistent with accepted standards of medical practice rendered at an appropriate level of intensity, can reasonablybe expected to promote effective outcomes, are provided efficiently and economically, facilitate quality of care and are not solely for the convenience of the Member, his/her family, the physician or other health care provider. The Chief Medical Officer or his/her designee shall have the authority to determine whether any Health Care Service rendered to a Member is a Medically Necessary Covered Health Care Service.

    We will not pay for any service, test or treatment which our Medical Director determines is not Medically Necessary for the diagnosis or treatment of your illness, injury or condition. Even if a service is listed as a Covered benefit, we will only pay for the service if our Medical Director determines that it is Medically Necessary and appropriate for your particular case.

    Examples of care that is not Medically Necessary are: when you are admitted to a Hospital for care which could have been provided in a physician's office or provided without admission to a Hospital as a bed patient; when services are performed in a freestanding ambulatory surgery center which could have been performed in a physician's office; when you are in a Hospital for longer than is necessary to treat your condition; when Hospitalized, you receive an ancillary service not required to diagnose or treat your condition; when the care is provided in a more costly facility or setting than is necessary; when you receive an inappropriate or non-essential service to diagnose your condition; when the services you receive are more costly than is necessary for the proper treatment of your condition.

34. **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.

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

36. **Member Liability**: the amount a Member must pay for Covered services, including Deductible, Coinsurance, Copayment, and other payments as set forth in this Contract.

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

38. **Non-Covered Service(s)**: any health care services not Covered by the Contract.

39. **Non-Participating Provider**: a licensed Physician; hospital; skilled nursing facility; home health agency; ambulance service; laboratory; or other duly licensed or certified Health Care Provider that does not have a Participating Provider agreement to provide Health Care Services to our Members.

40. **Open Enrollment Period**: 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.

41. **Out of Plan Authorization**: written authorization from our Medical Director for out of plan services.

42. **Out-of-Pocket Maximum**: means the maximum Deductible, Copayment, and/or Coinsurance amount that each Member pays Out-of-Pocket under this Contract (excluding any applicable routine refractive vision services, optical dispensing, hearing aids and hearing aid supplies, pharmacy benefits, or balance billing for out-of-area Urgent Care provided under the Contract).

After the Out-of-Pocket Maximum is met, we will pay for all Covered Health Care Services in full (excluding any applicable routine refractive vision services, optical dispensing, hearing aids and hearing aid supplies, out-of-area Urgent Care, or pharmacy benefits provided under the Contract).

For out-of-area Urgent Care, once the Out-of-Pocket maximum has been met, reimbursement will be the lesser of the Non-Participating Provider's billed charges or as applicable; the negotiated rate which the Non-Participating Provider has agreed to accept; ; or the Usual, Customary and Reasonable Rate (UCR) for services rendered outside our Service Area. UCR is determined at the 80th percentile.

The Out-of-Pocket Maximum does not include additional amounts paid by the Member for non-Covered benefits or amounts in excess of our reimbursement for out-of-area Urgent Care.

43. **Participating Pharmacy**: a pharmacy, firm, person, corporation or other association licensed and/or registered to practice pharmacy and has entered into a Participating Agreement with us.

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

Primary Physician: a Participating Physician:

i. who is selected by a Member with the approval of the Physician and Independent Health; and

ii. who is responsible for providing all primary care services including periodic examinations; immunizations; diagnosis and treatment of illness and injury; coordination the Member's overall medical care and record maintenance; providing twenty-four(24) hour physician coverage; and

iii. Independent Health has been notified of this selection. The Subscriber, on behalf of himself and his Covered Dependents, agrees to choose a new Primary Physician in the event his Primary Physician no longer participates with Independent Health.

Specialty Physician: a Participating Physician who provides services to a Member for a particular illness or injury and has not been selected as the Member's Primary Physician.

45. **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 Participating Providers are independent contractors, relating to us by contract only, and are not employees or agents of ours. The number of Participating Providers is subject to change at any time, without notice except as required by law. Such change may not necessarily coincide with the Contract Year.

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

47. **Preauthorization**: authorization from us that a provider must obtain prior to receiving any of the services needing Preauthorization.

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

49. **Qualified Ob/Gyn Provider:** a Participating Health Care Provider 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.

50. **Rate/Remittance Endorsement**: an agreement between us and the Policyholder which sets forth the Premiums due and the term of this Contract.

51. **Renewal Date**: the date on which this Contract renews unless earlier terminated as provided in Section 7. The Renewal Date for this Contract is January 1, unless the Policyholder has entered into a written agreement with us for a different date.

52. **Rider(s)**: an amendment to the Contract purchased by the Policyholder, which changes the terms of 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 on the Effective Date of Coverage.

53. **Service Area**: 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.

54. **Subscriber or "you" or "your"**: any person who meets all relevant eligibility requirements under Section 3 of the Contract, who applies and is accepted for Coverage from us and for whom the monthly Premium has been received by us.

55. **Total Disability**: 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.

56. **Two Person Coverage**: coverage for which Premiums have been paid to Cover the Subscriber and one Family Dependent.

57. **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. Customary and Reasonable is set at no less than the 80th percentile of amounts charged in the locality where the services are rendered.

58. **Utilization Review**: the process of making medical management decisions and is provided by us pursuant to Article 49 of the Insurance Law. See the Member Handbook for Utilization Review procedures and how to appeal a Utilization Review decision.

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 3: ELIGIBILTY, ENROLLMENT AND CONDITIONS OF COVERAGE

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 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; or proposed Adoptive Child who is:

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

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

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

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

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

         3) 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/payment is not received by us on or before the 30th day from the date upon which the child is physically in the household of the Member, then Coverage will begin on the date we receive notice.

      iv. 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 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 l egal obligation for the total or partial support of the infant in anticipation of adoption.

If we do not receive notification/payment of additional Premium, if any, on or before the 30 th day from the date of birth, then Coverage will begin on the date we receive notification/payment.

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.

c. An unmarried child of the Subscribe r 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 Family Dependent status has been extended by a Rider in which case the age limit of the Rider shall apply. The Family 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 Family Dependent child.

d. A new Family Dependent, because of marriage, birth of a child, or adoption of a child, may be enrolled duri ng 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 (30 th) 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 (30 th) 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 within one (1) year of the child's birth.

3. 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 Family Dependent child, except as provided in paragraph 6 below.

4. We reserve the right to examine a Policyholder's records including payroll records and an individual's health, employment or membership records in determin ing eligibility status for membership or under certain benefit exclusions such as, but not limited to, workers' compensation.

5. We reserve the right to request and be furnished with such proof as may be needed to determine eligibility status of a Member.

6. Grandchild (ren): A grandchild (ren) who resides in a Subscriber's household will be Covered as a Family Dependent to the Group Health Contract when the grandchild (ren) is claimed as a dependent on the Subscriber's income tax form. The Subscriber shall provide us a copy of his/her income tax form upon request.

7. Legal Guardianship. A copy of the legal guardianship papers must be submitted to us.

8. Foster Child (ren). A foster child (ren) who resides in a Subscriber's household will be Covered as a Family Dependent to the Group Health Contract when the foster child (ren) is claimed as a dependent on the Subscriber's income tax form. The Subscriber shall provide us a copy of his/her income tax form upon request.

ENROLLMENT

1. Subscribers may be enrolled with us only on the Policyholder's anniversary date or during a special enrollment period as described below and upon meeting the eligibility requirements imposed by the Policyholder or during open and special enrollment periods agreed upon by both the Policyholder and us.

2. A potential Subscriber who meets all applicable eligibility requirements may enroll other than during the Policyholder's Open Enrollment Period when one of the following changes in status occurs which is considered a special enrollment period and when proof of such situation is presented to us:

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

   b. exhaustion of COBRA continuation coverage or meeting or exceeding lifetime benefit limits of coverage;

   c. an involuntary loss of health insurance coverage resulting from a loss of eligibility, no longer living or working in an HMO's service area if that was the only coverage available to the individual, loss of dependent status, plan ceases to be offered to employees, the insurance company ceases offering group coverage, a benefit option is terminated and not replaced 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 who meets all applicable eligibility requirements may enroll other than during the Policyholder's Open Enrollment Period:

   a. when the person becomes a Family Dependent of the Subscriber through marriage; 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 Family Dependent if otherwise eligible; or

   b. the spouse or Family Member meets the requirements of 2. b or c. above and the employee is enrolled as a Subscriber.

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 to become Covered.

5. Changes to the original Application Form must be made by completing a Change of Status 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 of the Contract or at any later date agreed upon by both the Policyholder and us; and for newly eligible Subscribers, at the date when the Application Form is received by us and first month's Premium is paid to us.

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 for any services not Covered under an extension of benefits in accordance with 11 NYCRR 52.17 or 11 NYCRR 52.18 or other comparable provision.

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CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 4: BENEFIT ENDORSEMENT AND SCHEDULE OF COVERAGE

COVERAGE UNDER THIS CONTRACT

Coverage is subject to the Exclusions and Limitations of this Contract. Benefits under this Contract are available to Members in accordance to the terms stated in this Contract. Neither Independent Health nor any of its affiliates shall have any liability for any service received that was not in accordance with the terms stated in this Contract.

Payment for professional services under this Contract shall be arranged by us. Payment may be made to the provider, or directly to the Subscriber, as determined by us. **The Member is responsible for paying any Deductibles, Coinsurance and Copayments for Covered Services and items; please see the SCHEDULE OF COVERAGE for Deductibles, Coinsurance, Copayments and benefit maximums.**

Subject to the limitations of the Contract, the services and items listed in this section will be Covered only when (a) Medically Necessary and (b) provided by a Participating Provider except in a Medical Emergency or as provided below. A listing of Participating Providers, the Independent Health Provider Directory, is provided at no cost and contains relevant information for Members to access the Participating Provider network.

1. OUT OF PLAN AUTHORIZATION PROVISIONS

A Member may obtain an Out of Plan Authorization to a Non-Participating Provider, provided that all the following conditions are met:

a. There is no Participating Provider with appropriate training and experience to meet the particular health care needs of the Member as determined by our Medical Director,

b. The care of services are Medically Necessary,

c. The Member obtains a prior written authorization from the Medical Director. The Member's physician may obtain such authorization from the Medical Director on the Member's behalf. This approval is waived for Medical Emergencies.

PROFESSIONAL SERVICES

1. PROFESSIONAL SERVICES IN AN OFFICE SETTING

1.1 **Office and Home Visits** including:

- Periodic routine health examinations as determined by age and sex or when Medically Necessary;
- Immunizations for Members age nineteen (19) or older;
- Consultations by Specialty; Attending; or Designated Physicians;
- Voluntary family planning services (i.e. contraceptive education and counseling regarding methods to reduce unintended pregnancies and to improve birth spacing and outcomes);
- Allergy tests performed in the physician's office and allergy injections (any laboratory tests not performed in the physician's office and all other diagnostic services are Covered separately);
- Eye exams for medical conditions;
- Health education services provided to the Member by a Health Care Provider as part of and in conjunction with Covered Health Care Services;

- Injections given by a Participating or Designated Physician in the physician's office, except for self-injectable drugs, subject to the approval from our Medical Director;
- Physician house call to a Member in his/her home or in a Skilled Nursing Facility;
- Second medical opinions;
- Second surgical opinions;
- Second opinion regarding cancer for 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. This benefit requires a written referral from the Member's Attending or Primary Physician. The referral is an authorization for services, a copy of which must be provided to us. If the Member obtains written referral to a Non-Participating Physician and provides us with a copy, the Member is only responsible for the applicable Deductible and Coinsurance under this agreement.

1.2 **Prenatal and Post-Partum Care.** Prenatal office visits after Diagnosis of pregnancy up to delivery of child (or children) and post-partum visit. Prenatal care includes only office care rendered by a Qualified Ob/Gyn Provider, and does not include other services such as laboratory, X-ray and imaging services, or diagnostic services.

1.3 **Well-Child Visits** (including a medical history; physical examination; developmental assessment; anticipatory guidance; necessary and appropriate immunizations in accordance with Advisory Committee on Immunization Practices (ACIP) standards; 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 that the visits are made to or by the Dependent Child's Primary Physician or authorized licensed professional; and provided further that the visits are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

1.4 **Surgical Procedures when performed in the office.**

1.5 **Laboratory and Pathology Services.**

1.6 **X-ray and Imaging Services** for diagnostic purposes including, sonogram, ultrasound, MRI, PET and other imaging services.

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

1.8 **Diagnostic Services** including electroencephalograms, electrocardiograms, and similar diagnostic services.

1.9 **Hearing Examinations** ordered by a physician to determine the need for corrective aids.

1.10 **Chiropractic Care:** Medically Necessary care by a licensed chiropractor for symptoms such as pain, lack of physiological function caused by 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 our Medical Director. This care must be provided in connection with the detection and correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body.

1.11 **Nutritional Counseling** when prescribed by a Participating Physician.

1.12 **Annual Cervical Cytology Screening** for women eighteen (18) years of age or older, or before age eighteen (18) upon recommendation of physician 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.

1.13 **Diagnostic Screening for Prostate Cancer** for standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen (PSA) test, subject to the following limitations:

- Screenings at any age for men having a prior history of prostate cancer;
- Screenings annually 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.

1.14. **Infertility Services:**

Infertility Defined. Infertility means the inability to conceive after twelve (12) consecutive months (six (6) consecutive months for women over 35 years of age) of reasonably frequent contraceptive free, unprotected sexual intercourse with a member of the opposite sex and with 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. This definition is no less favorable than that established and adopted by the American Society for Reproductive Medicine.

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.

Eligibility for Services: In order to be eligible for Infertility Services as defined herein and as mandated by Chapter 82 of the Laws of the State of New York 2002, the Member must:

a. be at least twenty one (21) years of age and no older than forty four (44) years of age 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;

c. have a treatment plan that is in accordance with standards and guidelines established and adopted by the American Society for Reproductive Medicine; and

d. receive Preauthorization from us.

e. This benefit does not Cover treatment for the Member's partner if the partner is not our Member.

f. This benefit does not include prescription drugs.

Services provided to treat a correctable medical condition which would otherwise be Covered under this Contract are not subject to the above limitations solely because the medical condition results in Infertility.

These services are rendered in several settings by various professionals. The Member is responsible for paying the applicable Deductible and Coinsurance for each specific service provided as described in the Schedule of Coverage.

1.15 **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 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.

2. PROFESSIONAL SERVICES IN A HOSPITAL, SKILLED NURSING FACILITY, OR AN AMBULATORY CARE FACILITY

2.1 **Physician Procedures** including:
- Surgery, including:
  - Assistant Surgeon – a surgeon who assists another surgeon during the course of the procedure .
  - 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 symmetri cal appearance. There is also Coverage for physical complications associated with all stages of mas tectomy including lymphedemas and prostheses required because of a mastectomy.
- Other outpatient procedures including, but not limited to, colonoscopy, endoscopy, and angiograms.

2.2 **Anesthesia:** General and local anesthesia services.

2.3 **Surgical Pathology.**

2.4 **Obstetrical Services for Delivery.**

2.5 **Initial Newborn Care** (excludes circumcision, which is a surgical service).

2.6 **Inpatient Physician Visit** while the Member is a bed patient in the Hospital (including newborns) or Skilled Nursing Facility.

2.7 **Health Education Services** provided to the Member by a Health Care Provider as part of and in conjunction with Covered Health Care Services provided by a Health Care Provider in Hospital, Skilled Nursing Facility, or an Ambulatory Care Facility.

This section does not describe the services for mental health and psychiatric care. Please refer to the appropriate sections of this Benefit Endorsement and the Schedule of Coverage regarding mental health and psychiatric care services.

HOSPITAL, HOSPICE AND SKILLED NURSING FACILITY SERVICES

1. INPATIENT SERVICES

Hospital Defined. Hospital means 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 physicians; (2) has 24 -hour nursing services by registered professional nurses; (3) is not (other than incidentally) a place for rest, c ustodial 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.
Hospice Care Defined. Hospice Care means 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 p rocess required by the state in which the hospice is located. This does not include care provided for the purpose of giving respite services to the caregiver(s) of the patient.

Medical Rehabilitation Defined. Medical Rehabilitation means inpatient rehabilitative treatment requiring medical and/or nursing supervision twenty-four hours per day in a Medical Rehabilitation unit/facility to provide intensive multidisciplinary therapies to a Member who has sufficient medical stability, physical endurance, and cognitive capability allowing for cooperation, and an expectation for clinical and/or functional improvement, with discharge to a less intensive setting .

***Semi-Private Room** Defined*. means a room with two or more beds in a Hospital; Skilled Nursing Facility; or other participating health care facility. If you are in a private room at a Hospital or Skilled Nursing Facility, you must pay the difference between the cost of a private room and a Semi-Private Room unless the private room is Medically Necessary and ordered by your Participating or Designated Physician in accordance with this Contract. The applicable Deductible and Coinsurance for inpatient services still applies.

***Skilled Nursing Facility (SNF) Defined*.** Skilled Nursing Facility mean an inpatient facility providing therapeutic services to a Member 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.

1.1 **Inpatient Hospital Services**, including:

- Daily room and board, including special diets;
- General nursing care;
- Facility charges for use of operating and recovery rooms;
- Intensive care and cardiac care;
- X-ray and imaging services for diagnostic purposes including, sonogram, ultrasound, MRI, PET and other imaging services;
- Diagnostic services such as electroencephalograms and electrocardiograms;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals, vaccines, intravenous preparations;
- Dressings and casts;
- Laboratory and pathological examinations;
- Physical rehabilitation services, including physical therapy, occupational therapy and speech therapy
- Chemotherapy;
- Radiation therapy (Radiotherapy);
- Dialysis services;
- Inpatient care for lymph node dissection, lumpectomy or mastectomy for such time as it is determined by the attending physician in consultation with the patient to be medically appropriate;
- Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract;
- End of life acute care: acute care services at an acute care facility licensed pursuant to Article Twenty Eight of the Public Health Law and specializing in the treatment of terminally ill patients if (a) the Member is diagnosed with advanced cancer (with no hope of reversal of the primary disease and fewer than sixty (60) days to live, as certified by the Member's Participating Physician), and (b) the Member's Participating Physician, in consultation with the medical director of the facility, determines that the Member's care would appropriately be provided by such a facility (For hospice services, please refer to the appropriate section of this Contract.). In the event that we feel that end of life acute care is not necessary, we will initiate an external appeal. Services for end of life acute care will continue until a decision is rendered.
- Hospital service is subject to all the rules and regulations of the Hospital and/or Skilled Nursing Facility. Hospital service is also subject to the rules and regulations that govern admission and discharge.
- If a Member stays in a Hospital or Skilled Nursing Facility after it is no longer Medically Necessary, the Member shall be responsible for all charges incurred by the physician, Hospital or Skilled Nursing Facility.
- The Member shall be liable for all charges after 12:00 p.m. of the date of discharge when:
  a. he/she is discharged before 11:00 a.m.; and
  b. he/she fails to leave before 12:00 p.m. of the same day.
- The days in a Hospital or Skilled Nursing Facility shall be consecutive in each confinement. The Member shall not select the day or days for which benefit shall be made.
- The day of admission and not the day of discharge will be counted when computing the number of days of Hospital service.

1.2 **Maternity Care and Newborn Care.** Inpatient Hospital 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, and

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

Each Member requiring maternity care shall be entitled to maternity care, provided that other than care for perinatal complications, such maternity care shall include inpatient 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 (1) home care visit. The home care visit may be requested at any time within forty-eight (48) hours of the time of delivery (ninety-six (96) hours in the case of caesarean section). Such home care visit shall be in addition to home care services otherwise available under this Contract and is not subject to Deductibles, Coinsurance or Copayments.

1.3 **Skilled Nursing Facility Services** must be ordered by a Member's physician as an alternative to Hospitalization. Central supply items, drugs, medications, biologicals and vaccines are Covered when rendered as part of a Covered Skilled Nursing Facility stay.

1.4 **Medical Rehabilitation** for inpatient treatment in an approved rehabilitation unit or facility which can result in a significant clinical improvement in a Member's condition. Admission must be within one (1) day of Hospital discharge for the same injury or illness.

1.5 **Hospice Care Services: Inpatient Hospice Care Services.** Care in a hospice or a Hospital including Medically Nescessary supplies and drugs.

Outpatient Hospice Care Services. Home care and outpatient services provided by hospice including Medically Necessary supplies and drugs.

Family Visits. Visits for bereavement counseling, either before or after the terminally ill Member's death.

Advanced Care Planning (ACP). Home visits sponsored by a hospice provider prior to admittance to a hospice program, to assist the Member with preparation for issues following a life threatening/terminal diagnosis.

2. OUTPATIENT HOSPITAL AND AMBULATORY CARE FACILITY SERVICES

2.1 **Services in a Hospital Outpatient Department or an Ambulatory Care Facility** , including:

- Facility charges for use of operating and recovery room;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals, vaccines, intravenous preparations;
- General nursing care;
- Dressings and casts;
- Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this C ontract.

2.2 **Laboratory and Pathological Examinations.**

2.3 **X-ray and Imaging Services** for diagnostic purposes including, sonogram, ultrasound, MRI, PET and other imaging services.

2.4 **Diagnostic Services** such as electroencephalograms and electrocardiograms.

2.5 **Pre-admission Testing** if performed in Hospital facilities prior to a scheduled admission. The tests must be 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 pre-surgical tests; and the Member is physically present at the Hospital for the test.

2.6 **Dialysis Services**.

3. BLOOD AND BLOOD PRODUCTS

3.1 Blood plasma and packed blood cells, except when participation in a volunteer blood replacement program is available to the Member.

3.2 Autologous donations of blood and blood components, when associated with a scheduled, Covered surgical procedure.

Please refer to the appropriate sections of this Benefit Endorsement and the Schedule of Coverage regarding:
- Mental health and psychiatric care services;
- Treatment of alcoholism and substance abuse services, including rehabilitation;
- Emergency room services;
- Short-term therapies and rehabilitative services.

MEDICAL EMERGENCIES AND URGENT CARE

Medical Emergency Defined. A Medical Emergency is the sudden onset of a medical 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.

Urgent Care Defined. 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. The Member may appeal any denial of Coverage. The appeal process is described in the Member Handbook.

UCR (Usual, Customary and Reasonable) Defined. Usual means 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. Customary and Reasonable is set at no less than the 80 th percentile of amounts charged in the locality where the services are rendered.

1. SERVICES FOR MEDICAL EMERGENCIES

1.1 **Hospital Emergency Room Services** for care for a Medical Emergency in the emergency room (ER) of a Hospital, whether or not the Hospital is a Participating Provider or in the Service Area.

The Member, or someone on his/her behalf, should notify us within forty-eight (48) hours of receipt of emergency care, or as soon as is practicable.

1.2 **PreHospital Emergency Medical Services (Ambulance)** for Members who experience a Medical Emergency, including:
- prompt evaluation and treatment, and/or
- non-air-borne transportation of the Member to a Hospital.

PreHospital Emergency Medical Services must be provided by a licensed Ambulance and must be Medically Necessary and required as a result of a Medical Emergency. Use of PreHospital Emergency Medical Services will be reviewed retrospectively to determine if they were Medically Necessary and required as a result of a Medical Emergency.

2. SERVICES FOR URGENT CARE

2.1 **After Hours Urgent Care Inside the Service Area** for Urgent Care performed at a Participating After Hours Urgent Care Center. Services provided at a Participating After Hours Urgent Care Center during your physician's office hours are subject to review for Medical Necessity. Participating After Hours Urgent Care Center is an alternative site of service which:

a. is for the purpose of managing Urgent Care during non-traditional physician office hours;

b. is not a substitute for routine care provided in the physician's office or as a substitute for care for a Medical Emergency at the emergency room of a Hospital;

c. is equipped to accommodate minor outpatient procedures;

d. provides ancillary services including laboratory and radiology;

e. directs the Member to receive any necessary follow-up care from the Member's physician; and

f. has entered into an agreement with us to provide Urgent Care to Members.

2.2 **Urgent Care Services Outside the Service Area** when the Member is unable to obtain care within our Service Area only until the Member can reasonably access care within the Service Area.

We will reimburse Urgent Care services provided outside the Service Area including all Preauthorized follow-up care at the lesser of billed charges or UCR cost for the service provided minus the applicable Deductible and Coinsurance for the specific service provided as described in the Schedule of Coverage. In addition to the applicable Deductible and Coinsurance, the Member is responsible for paying the difference, if any, between our reimbursement and the Urgent Care provider's charges. Th eapplicable Deductible and Coinsurance will apply per date of service per provider, even if the service(s) rendered by the provider would not require a Deductible and Coinsurance if the services(s) were provided in the Service Area. 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 outside the Service Area in order for these services to be Covered.

OTHER HEALTH CARE SERVICES

1. HOME HEALTH CARE SERVICES

Home Health Care Defined: Home Health Care is a program of Medically Necessary care provided in a Member's home by a Home Health Agency including, but not limited to, skilled nursing services. 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.

1.1 **Home Health Care** ordered by a physician in accordance with a treatment plan approved in writing by the Medical Director as an alternative to Hospitalization or treatment in a Skilled Nursing Facility (as defined in 42 USC Sec. 1935 et. seq.). Services eligible for Coverage 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 that are rendered in the home;
- Drugs and medications, including home infusion therapy prescribed by a physician, and laboratory services by or on behalf of the Home Health Agency, to the extent such items would have been Covered or provided if the Member were Hospitalized or confined in a Skilled Nursing Facility.

1.2 **Limitations and Exclusions**

- Deductible and Coinsurance applies to each Covered visit, even if multiple visits occur on the same day.
- Our Medical Director has the right to determine if Home Health Care is Medically Necessary. This determination can be made at any time during an episode of care.
- Long-term physical therapy, long-term rehabilitation, private duty nursing, respite care and custodial care are excluded.
- We will pay for Home Care Services only for as long as the Member would have otherwise been confined in a Hospital or Skilled Nursing Facility as a Covered stay.

2. MENTAL HEALTH CARE SERVICES

Active Treatment defined. Active Treatment means treatment furnished in connection with inpatient confinement or outpatient treatment for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health. Treatment pro vided pursuant to a written comprehensive diagnostic or treatment plan.

Biologically Based Mental Illness defined. Biologically Based Mental Illness means schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, anorexia and bulimia.

Children with Serious Emotional Disturbances defined. Children with Serious Emotional Disturbances means persons under the age of eighteen (18) years who have diagnoses of attention defici t disorders, disruptive behavior disorders, or pervasive development disorders and where there are one or more of the following:

a. serious suicidal symptoms or other life-threatening self-destructive behaviors;

b. significant psychotic symptoms (hallucination s, delusion, bizarre behaviors);

c. behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or

d. behavior caused by emotional disturbances that placed the child at substantial ri sk of removal from the household.

Inpatient Mental Health Care Services defined. Inpatient Mental Health Care Services means services provided to a Member who has been admitted to a hospital as defined in Section 1.03 of the Mental Hygiene Law or other facility licensed to provide psychiatric inpatient services in the state where services are provided.

Mental Health Condition defined**.** Mental Health Condition means a treatable behavioral manifestation of a condition that IHA determines: (a) is a clinical ly significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the curr ent American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Provider defined. Mental Health Provider means a duly licensed

a. psychiatrist; or

b. psychologist; or

c. licensed and registered clinical social worker (L CSW-R) as recognized by New York State. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or

d. registered nurse practitioner: a nurse with a Master's degre e or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided; must by certified and have a practice agreement in effect with a psychiatrist; or

e. Psychiatric Hospital or other facility licensed in the state where Inpatient Mental Health Care S ervices are provided; or

f. Professional corporation or university faculty practice corporation employing professionals as set forth in a, b, c, and d above.

Each of the above must be licensed to provide covered services in the state where such provider's services are provided and meet IHA's credentialing requirements.

Outpatient Mental Health Care Services defined. Outpatient Mental Health Care Services means office visits to a Mental Health Provider.

Partial Hospitalization defined. Partial Hospitalization (day or night care center) means a visit in a center maintained by an approved facility that has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program. A Partial Hospitalization program must provide Medically Necessary care that is provided in lieu of inpatient mental health hospitalization.

2.1 **Mental Health Care Services for Mental Health Conditions.**

Inpatient Mental Health Care Services - for Mental Health Conditions up to thirty (30) days of Active Treatment per Contract Year for all facility and diagnostic charges.

Partial Hospitalization for Mental health Care Services for Mental Health Conditions is covered. Two (2) Partial Hospitalization visits equal one (1) covered inpatient day and will count against the Inpatient Mental Health Care Services day limit.

Outpatient Mental Health Care Services – Up to maximum of twenty (20) visits per Contract Year whether individual or group therapy for evaluation and treatment of Mental Health Conditions. Services may be rendered by a Participating Mental Health Provider. Each visit to a Mental Health Provider counts against the visit limit and a separate Deductible and Coinsurance will be charged for each visit even if more than one visit occurs on the same day.

2.2 **Mental Health Care Services for Biologically Based Mental Illness and Children with Serious Emotional Disturbances.**

Inpatient Mental Health Care Services - for Biologically Based Mental Illness and Children with Serious Emotional Disturbances for all facility and diagnostic charges. Services may be rendered at a Participating Mental Health Provider.

Partial Hospitalization for Biologically Based Mental Illness and Children with Serious Emotional Disturbances is covered.

Outpatient Mental Health Care Services – Individual or group therapy for evaluation and treatment of Biologically Based Mental Illness and Children with Serious Emotional Disturbances. Services may be rendered by a ParticipatingMental Health Provider.

Benefits (including Partial Hospitalization) provided for Biologically Based Mental Illness and Children with Serious Emotional Disturbances will count against the benefit limits listed above for Mental Health Care Services for Mental Health Conditions. There are no day or visit limits for Medically Necessary treatment of Biologically Based Mental Illness and Children with Serious Emotional Disturbances.

3. ALCOHOLISM, ALCOHOL ABUSE, AND SUBSTANCE ABUSE TREATMENT SERVICES

Inpatient Substance Abuse Detoxification Defined: Acute medical admission for the purpose of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

Inpatient Substance Abuse Rehabilitation Defined: Inpatient care in a hospital setting or in a free-standing community-based facility where twenty-four hour care is provided under medical supervision. Chemical dependence inpatient rehabilitation services provide intensive management of chemical dependence symptoms and medical management/monitoring of physical or mental complications from chemical dependence to clients who cannot be effectively served as outpatients and who are not in need of medical detoxification or acute care.

3.1 **Medical Treatment for Inpatient Substance Abuse Detoxification** for abuse of, or addiction to, alcohol, or drugs on an inpatient basis.

3.2 **Medical Treatment for Inpatient Substance Abuse Rehabilitation** for abuse of, or addiction to, alcohol, or drugs on an inpatient basis.

3.3 **Outpatient Treatment of Alcoholism and Substance Abuse** for the Diagnosis and treatment of alcoholism, substance abuse or substance dependency.

The Member's outpatient visits may be used for family therapy related to the Member's or any family member's alcoholism or alcohol abuse, substance abuse, or substance dependency, subject to the benefit maximum specified in the Schedule of Coverage. Family therapy is available to Members regardless of whether the impaired person is receiving outpatient treatment for alcoholism or alcohol abuse, substance abuse, or substance dependency.

3.4 **Limitations**

a. Services must be provided by Participating Providers that are Facilities certified by the New York State Office of Alcoholism and Substance Abuse Services.

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.

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 abuse or dependence or substance abuse or dependence.

f. Treatment of associated health conditions will be Covered under basic Health Care Services of the Contract.

g. Drug toxicology is Covered only when Medically Necessary and when used in conjunction with screening for alcohol abuse/dependency, drug abuse/dependency and when the Member is an active outpatient receiving treatment for alcohol abuse/dependency or drug abuse/dependency.

4. DIABETIC SERVICES AND ITEMS

4.1 Medically Necessary diabetic supplies and equipment, when recommended or prescribed by a physician or other licensed Health Care Provider.

a. **Diabetic Equipment**, including 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

b. **Diabetic Supplies.** Test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets, and cartridges for the visually impaired.

c. **Insulin and Oral Agents** for controlling blood sugar. Diabetic insulin and oral agents must be obtained from a Participating Pharmacy.

d. **Self-Management Education and Education Relating to Diet** for persons diagnosed with diabetes from a 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 dietitian or registered dietitian upon the referral of a physician or other licensed Health Care Provider legally authorized to prescribe under Title Eight of the Education Law.

5. DURABLE MEDICAL EQUIPMENT (DME)/PROSTHETICS & APPLIANCES (P&A)

Durable Medical Equipment (DME) Defined. DME means items which can withstand repeated use; are solely used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury or disease; and are appropriate for use in the home.

Internal Prosthesis Defined. Internal Prostheses are prosthetic devices that are surgically implanted (other than dental) that replace all or part of an internal organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Internal prosthetic devices which are cosmetic are not Covered unless Medically Necessary or required post-mastectomy.

External Prosthetic Devices and Medical Appliances (P&A) Defined. External prosthetics are artificial replacements of a whole or part of a whole body part which is worn as an anatomic supplement on the outside of the body. It is used to replace non-functioning or missing body parts. Examples of external prostheses include, but are not limited to, artificial limbs, artificial eyes and ostomy supplies. Medical Appliances are devices which are used to support a weak or deformed part of the body including, but not limited to, trusses and rigid and semi-rigid devices which support the orthopedic system.

6. SHORT-TERM THERAPIES AND REHABILITATIVE SERVICES

6.1 **Chemotherapy.**

6.2 **Radiation Therapy** (Radiotherapy).

6.3 **Pulmonary Rehabilitation.**

6.4 **Cardiac Rehabilitation** following a heart transplant, Congestive Heart Failure (CHF), bypass surgery or a myocardial infarction.

6.5 **Physical Therapy, Occupational Therapy and Speech Therapy**

7. OTHER HEARING SERVICES

7.1 Hearing Aid Fitting and Evaluation

7.2 Hearing Aids and Supplies

8. ALTERNATIVE BENEFITS

8.1 In addition to the benefits specified in this Contract, if you voluntarily participate in an individual case management program we offer, we may Cover services furnished pursuant to an alternative treatment plan. We may Cover such alternative benefits if and only for so long as we determine in our sole judgment, that the alternative services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total benefits for which you would otherwise be entitled under this Contract in the absence of alternative benefits. If we elect to Cover alternative benefits for a Member in one instance, it will NOT obligate us to Cover the same or similar benefits for another Member in any other instance where the alternative treatment is NOT, in our sole judgment, Medically Necessary, cost-effective and feasible, nor shall it be construed as a waiver of our right to administer this Contract thereafter in strict compliance with its expressed terms.

If Coverage under an alternative treatment plan is to be terminated, we will provide at least ten (10) days written notice of the determination.

These services are rendered in several settings by various professionals. The Member is responsible for paying the applicable Deductible and Coinsurance for each specific service provided as described in the Schedule of Coverage.

SCHEDULE OF COVERAGE

To be Covered, all Health Care Services and items MUST be Medically Necessary and provided by a Participating Provider, or with Preauthorization from us when provided by a Non-Participating Provider. This approval is waived only for Medical Emergencies.

ONLY THOSE SERVICES AND ITEMS SPECIFICALLY IDENTIFIED AS COVERED IN THIS SCHEDULE OF COVERAGE ARE COVERED. Coverage is subject to the Limitations and Exclusions of this Contract. Some services and items that may be covered under other health benefit contracts may be noted as not Covered under this Contract.

Deductibles, Coinsurance, Copayments, and Out-of-Pocket Maximums.

Coverage for Medically Necessary Health Care Services rendered by Participating Providers or Non-Participating Providers with appropriate authorization are subject to the following Deductibles, Coinsurance, Copayments and Out-of-Pocket Maximums, unless otherwise stated:

a. Coverage is subject to a $100 Deductible per person per Contract Year. However, once two (2) family members have each met their individual Deductible, a family covered under this Contract s hall only be subject to a $200 total Deductible in a Contract Year, and the other members of the family will be considered to have met their Deductible for that Contract Year.

b. In addition to a Deductible, you must pay Coinsurance equal to 10% (Emergency Room is subject to a Copayment and no Deductible) of the Fee Schedule amount for the Participating Providers. After you have met your Deductible, we will pay90% of the Fee Schedule amount for the Participating Providers. For authorized Non-Participating Providers, Coinsurance is a percentage of billed charges or n egotiated rate, except for Urgent Care Services Outside the Service Area where Coinsurance is a percentage of UCR.

c. **Out-of-Pocket Maximums.** The maximum Deductible, Coinsurance, and Copayment amount that each Member pays out-of-pocket under this Contract is limited to $2000 per person and $4000 per family per Contract Year. The Out-of-Pocket Maximum does not apply to hearing aids, hearing aid supplies, routine eye exams, optical dispensing, and prescription drugs.

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COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
Professional Services		
Physician Office and Home Visits	Subject to Deductible and Coinsurance *	
Prenatal office visits	Covered in full after initial diagnosis*	
Well-Child visits	Covered in full*	
Surgical procedures when performed in the office	Subject to Deductible and Coinsurance*	
Laboratory and Pathology Services	Subject to Deductible and Coinsurance*	
X-ray and Imaging Services	Subject to Deductible and Coinsurance*	

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
Mammography	Covered in full*	
Diagnostic Services	Subject to Deductible and Coinsurance*	
Hearing Examinations ordered by a Physician	Subject to Deductible and Coinsurance	
Chiropractic Care	Subject to Deductible and Coinsurance	
Nutritional Counseling	Subject to Deductible and Coinsurance	
Annual Cervical Cytology Screening	Covered in full*	
Diagnostic Screening for Prostate Cancer	Subject to Deductible and Coinsurance*	
Infertility Services	Subject to Deductible and Coinsurance	
Bone Mineral Density Measurements	Covered in full*	
Professional Services in a Hospital, Skilled Nursing Facility, or an Outpatient Facility		
Physician Services for Surgery and Other Outpatient Procedures	Subject to Deductible and Coinsurance*	
General and Local Anesthesia Services	Subject to Deductible and Coinsurance*	
Surgical Pathology	Subject to Deductible and Coinsurance*	
Obstetrical Services for delivery	Subject to Deductible and Coinsurance*	
Initial Newborn Care	Subject to Deductible and Coinsurance	
Inpatient physician visit	Subject to Deductible and Coinsurance*	
Health Education Services	Subject to Deductible and Coinsurance	
Hospital and Skilled Nursing Facility Services		
Inpatient Hospital Services	Subject to Deductible and Coinsurance per admission	
Maternity Care	Subject to Deductible and Coinsurance per admission	
Newborn and Infant Nursery Care	Covered in full	

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
Skilled Nursing Facility Services	Subject to Deductible and Coinsurance per admission	Up to 120 days per Contract Year.
Medical Rehabilitation Services	Subject to Deductible and Coinsurance per admission	Up to 120 days per Contract Year.
Hospice Services		
Inpatient Hospice Services- Care in a hospice or in a Hospital including Medically Necessary supplies and drugs.	Covered in full	No day limitations apply
OutpatientHospice Services – Home care and outpatient services provided by hospice including Medically Necessary supplies and drugs.	Covered in full	No visit limitations apply
Family visits – Visits for bereavement counseling, either before or after the terminally ill Member's death.	Covered in full	No visit limitations apply
Advanced Care Planning (ACP) – Home visits sponsored by a hospice provider prior to admittance to a hospice program, to assist the Member with preparation for issues following a life threatening/terminal diagnosis.	Covered in full	The Member shall be eligible for a maximum of six (6) ACP visits per Contract Year.
Outpatient Hospital and Ambulatory Care Facility Services		
Facility charges for use of Operating and Recovery Room	Subject to Deductible and Coinsurance*	Medically Necessary cosmetic procedures require Preauthorization. Any other cosmetic procedures are not covered.
Laboratory and Pathology Services	Subject to Deductible and Coinsurance*	
X-ray and Imaging Services	Subject to Deductible and Coinsurance *	
Diagnostic Services	Subject to Deductible and Coinsurance*	
Pre-admission Testing	Subject to Deductible and Coinsurance*	
Dialysis Services	Subject to Deductible and Coinsurance	
Blood and Blood Products		
Blood plasma and packed blood cells	Subject to Deductible and Coinsurance	

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
Autologous blood	Subject to Deductible and Coinsurance	
Medical Emergencies and Urgent Care		
Hospital Emergency Room Services	$50 Copayment This Copayment will be waived when the Member is admitted as a bed patient immediately following the Emergency Room visit, for the same condition.	
PreHospital Emergency Medical Services (Ambulance)	Subject to Deductible and Coinsurance	
After Hours Urgent Care In the Service Area	Subject to Deductible and Coinsurance	
Urgent Care Services Outside the Service Area	Subject to Deductible and Coinsurance Balance billing may apply if provider bills in excess of UCR.	
Home Health Care		
Home Health Care (including Home Infusion Therapy)	Subject to Deductible and Coinsurance per visit	The Member shall be eligible for up to forty (40) visits per Contract Year. Up to four (4) continuous hours of home health aide services are counted as one (1) home care visit
Mental Health Care Services		
Inpatient Mental Health Care Services for Mental Health Conditions	Subject to Deductible and Coinsurance per admission	Up to thirty (30) days of Active Treatment per Contract Year
Partial Hospitalization for Mental Health Care Services for Mental Health Conditions	Subject to Deductible and Coinsurance per visit	2 Partial Hospitalization visits equal 1 inpatient day and count against the 30 inpatient days per Contract Year for Mental Health Conditions.
Outpatient Psychiatric and Mental Health Services	Subject to Deductible and Coinsurance	Up to twenty (20) visits per Contract Year
Inpatient Mental Health Care Services for Biologically Based Mental Illness and Children with Serious Emotional Disturbances	Subject to Deductible and Coinsurance per admission	Will count against the 30 inpatient days per Contract Year. No day limits apply for Medically Necessary treatment

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
Partial Hospitalization for Biologically Based Mental Illness and Children with Serious Emotional Disturbances	Subject to Deductible and Coinsurance per visit	2 Partial Hospitalization visits equal 1 inpatient day and count against the 30 inpatient days per Contract Year for Mental Health Conditions. No day limits apply for Medically Necessary treatment
Outpatient Mental Health Care Services for Biologically Based Mental Illness and Children with Serious Emotional Disturbances	Subject to Deductible and Coinsurance	Up to twenty (20) visits per Contract Year No day limits apply for Medically Necessary treatment
Alcoholism, Alcohol Abuse, and Substance Abuse Treatment Services		
Inpatient Treatment for Substance Abuse of, or addiction to, alcohol, or drugs	Subject to Deductible and Coinsurance per admission	Inpatient Services for Detoxification – Up to seven (7) days per inpatient admission Inpatient Services for Rehabilitation – Up to thirty (30) days per Contract Year
Outpatient Treatment of Alcoholism and Substance Abuse	Subject to Deductible and Coinsurance	Up to sixty (60) visits per Calendar Year 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 family member.
Diabetic Services and Items		
Diabetic Durable Medical Equipment	Subject to Deductible and Coinsurance	
Diabetic supplies	Subject to Deductible and Coinsurance per item	30 day supply
Insulin and Oral Agents	Subject to Deductible and Coinsurance or the Member's pharmacy copayment, whichever is less.	30 day supply
Diabetic Education	Subject to Deductible and Coinsurance	
Durable Medical Equipment (DME)/ Prosthetics & Appliances (P&A)		
DME	Subject to Deductible and Coinsurance	$1000 maximum per Member per Contract Year.
Internal Prosthetics	Covered in Full	

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

COVERED SERVICE OR ITEM	MEMBER LIABILITY PROVISION	BENEFIT MAXIMUM PER MEMBER
External Prosthetics and Medical Appliances (P&A)	Subject to Deductible and Coinsurance	
Short-Term Therapies and Rehabilitative Services		
Chemotherapy	Subject to Deductible and Coinsurance	
Radiation Therapy (Radiotherapy)	Subject to Deductible and Coinsurance	
Pulmonary Rehabilitation	Subject to Deductible and Coinsurance	24 visits per Contract Year
Cardiac Rehabilitation	Subject to Deductible and Coinsurance	36 visits per event.
Physical Therapy, Occupational Therapy and Speech Therapy	Subject to Deductible and Coinsurance	60 combined visits per Contract Year
Other Hearing Services		
Hearing Aid Evaluation and Fitting	Subject to Deductible and Coinsurance	
Hearing Aids and Hearing Aid Supplies	Covered in full up to allowance.	Adult (age 19+): Up to $1200 maximum once every 36 months for both ears combined. Child (age 0-18): Up to $1200 maximum once every 24 months for both ears combined. Any amounts paid out-of-pocket for Hearing Aids and Hearing Aid Supplies do not count towards your Deductible. The Out-of-Pocket Maximum does not apply. Any unused portion of the maximum allowance expires at the end of the above time periods.

*Preventive Services as defined specifically in the Preventive Care Amendment are covered in full when provided by a Participating Provider.

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 5: LIMITATIONS OF COVERAGE, EXCLUSIONS AND SERVICES NOT COVERED

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

1. GENERAL EXCLUSIONS

1.1 **Residential treatment for alcohol and substance abuse.**

1.2 **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, orthotic devices and supplies including shoe inserts except as explicitly provided in this Contract.

1.3 **Travel and transportation expenses** even though prescribed by a physician, except as provided in this Contract.

1.4 **Cosmetic services and items**. Any Health Care Service rendered for cosmetic purposes including any procedures which do not require Medically Necessary services, or any services or items connected with a cosmetic operation. A cosmetic Health Care Service is Covered only when it is Medically Necessary; for example: 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 Family Dependent child which results in a functional impairment. Examples of cosmetic services and items that are not Covered unless Medically Necessary include, but are not limited to:

- Rhinoplasty;
- Reconstructive surgery for scar repair or revision where no physiological functional defect is present;
- Cranial prostheses, wigs, and hair replacements;
- Cosmetic devices;
- Sex change procedures;
- Drugs and biologicals used for cosmetic purposes, even if the drug or biological is otherwise Covered under a Rider or amendment of this Contract.

1.5 **Custodial care**, rest cures, maintenance care and respite care.

1.6 **Replacement of lenses, frames and/or contact lenses** which are lost or broken.

1.7 **Safety glasses.**

1.8 **Contact lenses** for the sole purpose of changing and/or enhancing the appearance of the eye.

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

1.10 **Government and public facilities:** Treatment provided in a governmental Hospital and care for conditions that federal, state or local law requires be treated in a public facility.

1.11 **Medicare**: Benefits for which you are eligible, whether or not 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 a 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).

1.12 **Other government programs.** Benefits for which you are eligible under any other governmental program (except Title XIX of the Social Security Act), benefits provided by any state or federal workers' compensation, employer's liability or occupational disease law.

1.13 **No-fault:** 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.

1.14 **Acts of war and military service:** Any injury or sickness resulting from war or any act of war (declared or undeclared) or service in the armed forces of any country to the extent Coverage of such injury or sickness is provided through any governmental plan or program.

1.15 **Dental care**, including:

- Regular dental care. Any dental care and treatment including but not limited to orthodontia, prosthodontics, periodontics, dentures, devices & appliances used in conjunction with the teeth, 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.

- Dental care for TMJ. Temporomandibular disease (TMJ) can be either medical or dental in nature. Coverage for TMJ is excluded when it is dental in nature.

1.16 **Care for military service connected disabilities,** when:

- you are legally entitled to services, and

- facilities are reasonably available to you.

1.17 **Pre-existing Conditions**. 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 the Member's group health plan 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 with 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 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;

iv. Medicaid;

v. CHAMPUS;

vi. Indian Health Service or Tribal Benefits;

vii. State Health Benefits Risk Pool;

viii. Federal Employee Benefit Plan;

ix. A public health plan as defined in the federal regulations (which includes public health plans provided by foreign countries);

x. Peace Corps;

xi. State Children's Health Insurance Program.

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 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.

f. An individual and any dependent of such individual who is eligible for a federal tax credit under the Federal Trade Adjustment Assistance Reform Act of 2002 and who has three (3) months or more of Creditable Coverage.

We will adhere to the following rules to determine whether this Exclusion applies:

a. 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 that a person is in a waiting period or an affiliation period shall not be taken into account in determining the continuous period of Coverage unless the Creditable Coverage was health maintenance organization coverage.

b. A Pre-existing Condition exclusion shall not apply to any Member whose Coverage is obtained through a group of more than three hundred (300) Subscribers.

1.18 Mental health benefits or services for Members who are presently incarcerated, confined or committed to a local correctional facility or a youth custodial facility.

1.19 Mental health benefits or services and/or health care services solely because such services are ordered by a court.

1.20 Benefits or services that are deemed cosmetic in nature on the grounds that changing or improving a Member's appearance is justified by the Member's mental health needs.

1.21 Mental Health Conditions that are not Medically Necessary.

1.22 Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance.

1.23 Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non-disorder conditions which may be the focus of clinical attention (V codes).

1.24 Custodial care, rest cures, maintenance care and respite care. Custodial care is defined as help in transferring, eating, dressing, bathing, toileting and other such related activities.

2. SPECIFIC SERVICES AND ITEMS NOT COVERED

2.1 **Services and items not specified as Covered**: we will not provide Coverage for any service or item that is not specifically described by this Contract as Covered, even when:

- a Participating Provider prescribes the service or item, or otherwise considers it to be Medically Necessary and appropriate, or
- the service or item is not specifically identified by this Contract as excluded.

2.2 **Services and items which were not received in accordance with this Contract,** including, without limitation, any services and items 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 Service.

2.3 **Services and items that are not Medically Necessary.** Health Care Services and Items that are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or sickness or to maintain your health are excluded. The Contract Covers only Medically Necessary services unless otherwise specified.

2.4 **Prescription drugs and medications** except as specifically provided in this Contract.

2.5 **Self-administered injectables**. This exclusion does not apply to diabetic supplies and insulin as provided in this Contract.

2.6 **Long-term physical therapy or long-term rehabilitation.**

2.7 **Special nurses and attendants** or their board.

2.8 **Storage of blood or blood products**. This does not apply to autologous (one's own) 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.

2.9 **Optifast program** or other programs with dietary supplements.

2.10 **Wheelchair van transportation and ambulance service** except as specifically provided in this Contract.

2.11 **Private duty nursing**. Private Duty Nursing is care provided by an LPN or RN and required when the Member has a continuous skilled need as opposed to an intermittent skilled need such as a dressing change.

2.12 **Expendable medical supplies.**

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

2.14 **Computer-assisted communication devices** or electronic communications devices.

2.15 **Transplant donor expenses.** 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.

2.16 **Reversal of elective sterilization,** including, but not limited to:

- Reversal of Tubal ligation;
- Reversal of Vasectomy.

2.17 **Infertility Services** except as specifically provided in this Contract for medically Necessary medical and surgical care for Diagnosis and treatment of a correctable medical condition that results in Infertility. Excluded services include:

- 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 excluded Infertility Services are NOT Covered, even if the drug or biological is otherwise Covered under a Rider or amendment to this Contract;
- 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; and
- Sex change procedures.

2.18 **Items such as air conditioners**, humidifiers and athletic equipment and devices used for athletic activities.

2.19 **Television or phone charges** while an inpatient in any Hospital or skilled nursing facility.

2.20 **Court-ordered treatment for mental health conditions and/or Health Care Services or items** unless such treatment is determined to be Medically Necessary.

2.21 **Services and items that are not safe and/or efficacious.** 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 based on Medical Necessity. The Medical Director's determination is subject to appeal pursuant to Article 49 of the Public Health Law as set forth in the Member Handbook.

2.22 **Care from family members**. 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 .

2.23 **Services and items required by third parties**. Physical and mental examinations and immunizations, and drug testing required by third parties for obtaining or maintaining employment or insurance, medical research, travel, school, or camp and court ordered examinations and hospitalizations except when Medically Necessary.

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

2.25 **Non-compliance with discharge.** Any expense as a result of your failure to vacate any Hospital or skilled nur sing facility bed beyond the discharge date established by the facility, Participating Physician, you physician and us .

2.26 **Felony**. Services and items for which a contributing cause was your commission of or attempt to commit a felony.

2.27 **Medical record expenses.** 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.

2.28 **Any Health Care Services or items rendered after the termination of Coverage** except in the case you are determined to be eligible for benefits under the Continuation of Coverage provision of the Contract .

2.29 **Services for which payment has been made:** Any fees for the services of Health Care Provider employed by a Hospital or institution to which a global or case-based payment is made.

2.30 **Services prohibited by the government:** 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 an y agency of the federal, state, or local government in reliance on said law or regulation including clinical laboratory services, pharmacy services, x - ray or imaging services furnished pursuant to a referral prohibited by Public Health Law Section 238-a.

2.31 **Services provided in conjunction with services or items that are not Covered benefits.** This exclusion does not apply to otherwise Covered treatment for complications following a Non-Covered service.

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 6: CLAIM FILING AND COORDINATION OF BENEFITS

REIMBURSEMENT OF EXPENSES FOR TREATMENT BY NON-PARTICIPATING PROVIDERS WHEN APPROVED BY INDEPENDENT HEALTH OR FOR MEDICAL EMERGENCY SERVICES

A. **Claim Form.**
An itemized bill or, at our discretion, a Claim Form must be submitted to us by mailing to Independent Health Claims Department, PO Box 9066, Buffalo, NY 14231 within ninety (90) days after the date you incur expenses for Covered Services even if the expenses do not meet the Deductible, if applicable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if such itemized bill or Claim Form is furnished as soon as reasonably possible. But in no event, except in the case of 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 expenses for Covered Services 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 Appeals Procedures at Section 8, 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.

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 Allowable Expenses will be paid for, or provided by, all the benefit plans less any Copayments or any applicable 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 Covered services of Non-Participating Providers and as a secondary payor for any item of Allowable Expense as defined and required by the Insurance Department's regulations. 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, if applicable; 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.

RECOVERY OF PAID EXPENSES / RIGHT OF SUBROGATION

The Member understands and agrees to the following provisions regarding our right to recovery of paid expenses and right of subrogation.

1. When a Member receives 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 Member shall reimburse us for such expenses that we pay on the Member's behalf; and we shall have a lien upon such judgment, settlement, payment or other reimbursement to the extent we have paid Member's expenses.

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

   a. Independent Health is subrogated to all of the Member's rights against any party liable for the Member's 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 the Member. We may assert this right independently of the Member.

   b. The Member is 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, and signing and delivering such documents as we or our agents reasonably request to secure our subrogation claim.

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

   d. The costs of legal representation of us in matters related to subrogation shall be borne solely by us. The costs of the Member's legal representation shall be borne solely by the Member.

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 7: TERMINATION, CONVERSION AND CONTINUATION OF COVERAGE

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 8 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 or ceases to be eligible for Coverage pursuant to the Policyholder's requirements .

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 t he divorce decree. (For Conversion/Continuation Rights of Group Coverage with respect to any surviving Members, see Section 7).

8. You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under t he 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 Section 7).

10. Such other reasons as the Superintendent of Insurance may approve consistent with applicable law upon one (1) month's prior written notice.

11. Notice. Except as otherwise provided herein, we shall give the Policyholder at least thirty (30) days prior written notice of any termination or refusal to renew under this Section 7.

12. Change in Status under the definition of Family Dependent. If you are no longer Covered under this Contract because you are no longer within the definition of Family Dependent, your eligibility for benefits under this Contract shall terminate automatically and without notice. (For Conversion/Continuation Rights of G roup Coverage, see Section 7).

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 and surgical benefits shall be extended for 31 days for a Member who is Totally Disabled at the time of termination or non-renewal. Payment will be for the Hospital or surgical charges which result from the illness, condition or injury causing the Total Disability 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 skilled surgical services; physician and other services are not Covered.

14. Benefits will be provided after termination by reason of termination of active employment 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 under another Group Benefit Plan.

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.

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 Family 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. We are 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 Family Dependent child ceases to be a Family 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 7 is available when any period of Continuation of Benefits under this section ends.

SUPPLEMENTARY CONVERSION AND CONTINUATION OF COVERAGE PRIVILEGES APPLICABLE TO MEMBERS OF THE RESERVES AND NATIONAL GUARD

In addition to the conversion and continuation of coverage specified above, if you are a member of a reserve component of the Armed Forces of the United States, including the National Guard, you are eligible to have supplementary conversion and continuation privileges as set forth under New York State Insurance Law Section 4305. You are eligible for these privileges if you enter upon active duty (other than for the purpose of determining your physical fitness and other than for training) and serve no more than four years of active duty and the group contract holder does not voluntarily maintain coverage during your period of active duty.

In order to apply for the supplementary continuation or conversion coverage, you must request such continuation or conversion in writing within 60 days of being ordered to active duty. You must pay the required Premium for continuation coverage to the group contract holder, monthly in advance, at the group rate for the benefits being continued under the group contract on the due date of each

payment. Continuation shall cease on the date which you first become entitled to coverage under Medicare or covered by any other insured or uninsured arrangement which provides hospital, surgical or medical group co verage, except that the supplementary coverage available to active duty members of the uniform services and their family members shall not be considered group coverage under the terms of this subsection and except that the supplementary conversion option u nder this subsection shall also not be considered as group coverage. If you are eligible for COBRA coverage due to the Subscriber's call to active duty, then the supplemental continuation and conversion rights do not apply. The payment and other terms of the conversion contract are set forth in the conversion contract. If you elect the supplementary continuation rights or coverage under the Group plan is suspended, and you die during the period of active duty, the supplementary conversion right provided herein shall be available to your surviving spouse and children, and shall be available to a child solely with respect to him or herself upon attaining the limiting age of coverage under the Group contract while covered as a dependent. If your marriage en ds through divorce or annulment during the period of active duty, your former spouse shall also be eligible for supplementary conversion.

The supplementary conversion and continuation coverage provided for members of the reserves and National Guard such c overage shall end on the date that you are either re-employed or restored to participation in the group coverage. If you are not re-employed or restored to participation in the group coverage upon return to civilian status, you shall be entitled to the ot her conversion and continuation rights set forth in this Section 7, for which you must apply to us within 31 days of the termination of active duty or discharge from hospitalization incident to such active duty, when hospitalization continues for a period of not more than one year. You shall also be eligible for an individual conversion contract at the end of your period of continuation coverage.

In addition to the supplementary conversion and continuation privileges afforded under Section 4305 of the New York State Insurance Law there is also a right of resumption of group coverage as follows: if you are either re-employed or restored to participation in the Group upon return to civilian status, you shall be entitled to resume participation in insurance offered by the Group with no limitations or conditions imposed

CITIGROUP INC.
GROUP HEALTH CONTRACT
SECTION 8: GENERAL PROVISIONS

CONTRACT PROVISIONS

A. Premium Payment-Computation.

All Premiums are payable monthly in advance by the Policyholder to us at the address indicated on the Policyholder's Premium bill. 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 its Subscriber and shall not, under any circumstances, be our agent; employee; or representative in collecting any amounts from such Subscriber and paying it to us.

The initial Premium for Coverage is set forth in the Rate/Remittance Endorsement. We will provide the Policyholder with at least thirty (30) days notice of the Effective Date of any Premium increase or decrease.

We shall calculate the Premium based upon our records of the number and Coverage of Subscribers and Dependents on or about the middle of the month preceding the date that the next month's Premium is due and payable. The Policyholder shall provide us with a list of deletions or additions of any Members to be Covered or not to be Covered by us.

If the information is not received in time for the next month's invoices, 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 within thirty (30) days of the Eligibility Date or date of termination.

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.

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 sixteenth (16th) and the last day of any month.

B. Grace Period.

A grace period of thirty (30) 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 thirty (30) 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 further 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.

RELATIONSHIP OF PARTIES AND PROVIDERS

No provision of this Contract is intended to create, nor shall be deemed or construed to create, any relationship or joint v enture among Policyholders, you and us other than as independent entities contracting with each other solely for the purpose of effectuating the provisions of this contract. Neither Policyholders, you or us, nor any of their respective employees, shall be deemed or construed to be the agent, employee or representative of the others, and shall not bind the others.

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.

GRIEVANCE AND APPEAL PROCEDURE AND UTILIZATION REVIEW APPEALS

1. **Grievance-Procedure:** You have the right to make any kind of complaint. If the complaint is about our decision that health care services requested or provided are not Medically Necessary , that decision can be appealed using the procedure described in the Utilization Review section below. All other kinds of complaints, including complaints about access to referrals or a decision that a service is not a covered benefit, are handled through our Grievance Procedure described below. We will not take any action against you if you complain or file an appeal.

A. **Filing a complaint/grievance:** You or someone you designate can complain by telephone by calling Member Services at **716-631-8701 or 1-800-501-3439**, between 8:00 a.m. to 8:00 p.m., Monday through Friday or in writing to:

Independent Health
Attention: Member Services
511 Farber Lakes Drive
Buffalo, New York 14221

You can also complain at any time to the New York State Department of Insurance on -line at www.ins.state.ny.us or writing to : Consumer Services Bureau, NYS Insurance Department, One Commerce Plaza, Albany, NY 12257.

B. **Acknowledgement and investigation by Independent Health.** We will investigate and respond in writing. Within 5 working days after we receive your complaint, we will send you a lette r telling you who is investigating it, how you can reach that person, and what additional information, if any, is needed to resolve your complaint.

C. **Decision.** If a delay in resolving the complaint could significantly increase risk to your health, we w ill make a decision within 48 hours after receipt of all necessary information and tell you right away. If your complaint involves a request for referral or a question about covered benefits, we will make a decision within 30 calendar days. In all other cases we will make a decision within 45 days after receipt of all necessary information.

D. **Appeal.** When we tell you how your complaint has been addressed, we will tell you why we made our decision and what rights you have to appeal the decision. If yo u are still not satisfied, you may send a written appeal to the address above. Appeals must be made within 60 business days after you receive the letter telling you about our decision. Within 15 business days after we receive your appeal, we will send yo u a letter telling you who is working on your appeal, how you can reach that person, and what additional information, if any, is needed to resolve your appeal. Staff at higher level than those who made the first decision will review appeals. They will include qualified clinical staff when medical issues are involved. Appeals are decided within 2 business days after receipt of all necessary information when a delay would significantly increase the risk to health, and within 30 business days after receipt of necessary information in all other cases. We will give you a detailed explanation of the outcome, including any medical reasons for the decision. If you have additional rights to appeal, we will tell you this too.

2. **Utilization Review Appeals**. Utilization Review (UR) is the process for deciding whether care is Medically Necessary and will be authorized or paid for by Independent Health. If we decide that the services for which authorization or payment is requested are or were not Medically Necessar y we will let you know by sending you a letter called an "Adverse Determination." We will state the reasons for the decision and explain how you or your doctor can appeal if you are not satisfied. We will not take any action against you if you appeal.

A. **Reconsideration:** If we decide not to authorize services that your health care provider recommends and we have not talked with that provider, the provider can ask us to reconsider the decision. The reconsideration will be done within one business day of the request. To request a reconsideration, your provider must call Independent Health's Medical Resource Management Department at 716-631-3425 or 1-800-711-6202. Calls to that number placed Monday through Friday from 8:30 a.m. to 5:00 p.m. will be answered by one of our qualified staff. Calls placed at other times will be answered by voice mail. Our staff will respond to your voice mail messages on the next business day.

B. **Filing an Appeal**. A UR decision that requested services are not Medically N ecessary or are not covered because they are experimental or investigational is called an "adverse determination" and it can be appealed. To appeal an adverse determination, you, someone you choose, or your health care provider must call or send a written request and supporting documents to:

Independent Health
Benefit Administration
511 Farber Lakes Drive
Buffalo, New York 14221

You have at least 180 days to appeal. The 180 day period begins when you receive an adverse determination from us.

C. **Appeal Decision**. If the decision involves continuing treatment that has been started or if your health care provider thinks an immediate appeal is needed, you are entitled to an "expedited" (faster) appeal process, with a decision to be made within 72 hours after we receive the necessary information. Other appeals will be handled under the standard appeals process. Those decisions will be made within 60 days after we receive the necessary information. If you are not satisfied with the outcome of an expedited appeal, you will also have the option of filing an appeal through our standard appeals process. Failure by Independent Health to make an appeal decision within the required time period will be considered a reversal of the initial adverse determination. T he result is approval of the service or benefit that was initially denied.

We will send you written notice of any decision to deny your appeal. This notice is called a final adverse determination. The notice will state the reasons for our decision and w ill tell you about any additional appeals that are available to you, such as external appeal. We will also include instructions and forms that you can use to apply for a New York State external appeal. See External Appeal section below.

EXTERNAL APPEAL

A. **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.

B. **Your Right to Appeal a Determination That a Service is Not Medically Ne cessary.** 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:

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

2. 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.

C. **Your Right 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:

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

2. 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. 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. 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.

D. **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) or the New York State Department of Health at (518) 486-6074, or its website (www.health.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.

E. **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.

OTHER PROVISIONS

A. Entire Contract.

The Contract, the application of the Policyholder, the Rate/Remittance Endorsement, 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 President of Independent Health. 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 Contract. You also authorize 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, 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 Contract; 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 and 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. Non-Covered Services.

The Member shall pay the Health Care Provider for any services that are not covered by this Contract.

J. Refusal of Treatment

Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by a Participating Physician or Designated Physician. We may regard such refusal to accept such recommendations as incompatible with the continuation of the physician/patient relationship and as obstructing the rendering of proper health care. If a Member refuses to accept such a recommended treatment or procedure, and we believe that no professionally acceptable alternative exists, such Member shall be so advised.

K. Certificate.

We will issue to the Subscriber this Certificate describing the Health Care Services to which he or she is entitled.

L. Severability.

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

M. 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.

N. Pronouns.

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

O. 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.

P. Events Beyond Our Control.

In the event of circumstances not reasonably within our control (such as war; riot; civil insurrection; or similar causes), we shall not be responsible for the performance of our obligations under this Contract provided however that we shall resume performance of its obligations under this Contract as soon as reasonably possible. In the event our services from Participating Providers are interrupted because of lack of facilities, labor disputes, or other causes, we will be responsible for payment of services provided by other providers to the extent required by this Contract.

Q. 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.

R. 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.

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

BENEFIT ENDORSEMENT TO PHARMACY RIDER

When dispensed by a Participating Pharmacy in accordance with Independent Health's Drug Formulary, the Member's liability for up to a thirty (30) day supply of Covered Drugs is as follows:

FORMULARY TIERS	MEMBER LIABILITY
FORMULARY TIER 1 DRUGS	$10
FORMULARY TIER 2 DRUGS	$20
FORMULARY TIER 3 DRUGS	$40

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

INDEPENDENT HEALTH BENEFITS CORPORATION

BY: _____
President