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The Research Foundation for SUNY

Blue Cross Blue Shield Global Expat

Certificate of Coverage Number: 4EL-7018-22

Effective Date: January 1, 2022

Policy Year: January 1, 2022 to December 31, 2022

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Policy between 4 Ever Life Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-Network benefits are the highest level of coverage available. In-Network benefits apply when Your care is provided by Participating Providers in Our GeoBlue network and Participating Pharmacies in Our Universal Rx network. You should always consider receiving health care services first through the in-network benefits portion of this Certificate.

2. **Out-of-Network Benefits.** The Out-of-Network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive Out-of-Network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. See the Schedule of Benefits section of this Certificate for more information.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

PRESIDENT

SECRETARY

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I. Explanation of Terms

You will find terms starting with capital letters throughout Your Certificate of Coverage ("Certificate"). To help You understand Your benefits, most of these terms are defined in the Definitions section of Your Certificate.

This Certificate, and any attached riders, is issued by 4 Ever Life Insurance Company ("Insurer") through a Policy issued to the HTH International Group Insurance Trust (the Policyholder). The Insurer will use a third-party Administrator to perform certain of its duties on its behalf. The Group and the Participant are hereby notified of the use of Worldwide Insurance Services, LLC as its Administrator.

4 Ever Life Insurance Company and Worldwide Insurance Services, LLC are Independent Licensees of the Blue Cross Blue Shield Association.

The benefits, limitations, exclusions and other coverage provisions in this Certificate are subject to the terms of Our Policy with the Group. This Certificate, and any attached riders, are a part of that Policy, which is on file in the Group's office and at Worldwide Insurance Services, LLC. This Certificate replaces any other benefit Certificate You may have received. The Group has delegated authority to Worldwide Insurance Services to use its expertise and judgment as part of the routine operation of the Plan to reasonably apply the terms of the Policy for making decisions as they apply to specific eligibility, benefits and claims situations. This does not prevent You from exercising rights You may have under applicable state or federal law to appeal, have independent review of Our judgment and decisions, or bring a civil lawsuit challenging any eligibility or claims determinations under the Policy, including the exercise of Our judgment and expertise.

This Plan's benefits and Your Out-of-Pocket expenses depend on the Providers You see. In this section You will find out how the Providers You see can affect this Plan's benefits and Your costs.

This Plan makes available to You sufficient numbers and types of Providers to give You access to all covered services. Our Provider networks include Hospitals, Physicians, and a variety of other types of Providers.

This Plan does not require use or selection of a Primary Care Physician, or require referrals for specialty care. Covered Persons may self-refer to Providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

Coverage Area
Benefits under this insurance are available in the following locations:

- Any country outside of the United States, including the eligible Participant's Home Country
- Inside the United States

Note: whenever coverage provided under this Plan would be in violation of any U.S. economic or trade sanctions, such coverage shall be null and void.

BlueCard® Program and Other Inter-Plan Arrangements

4 Ever Life Insurance Company and GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to Non-Participating Providers. Whenever You obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when You receive covered services from hospitals, doctors, and other Providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, You may also obtain care from Non-Participating Providers. Our payment calculation/practices in both instances are described below.

It is important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this Plan.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever You obtain healthcare services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside of Our service area, You may obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from Non-Participating healthcare Providers. Our payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

  Whenever You access covered healthcare services outside of Our service area and the claim is processed through the BlueCard® Program, the amount You pay for covered healthcare services is calculated based on the lower of:
  - The billed covered Charges for Your covered services; or
  - The negotiated price that the Host Blue makes available to Us.

  Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue to Your healthcare Provider. But sometimes it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and other credits or Charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

  Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation or modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

  Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, We would then calculate Your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers** Your Liability Calculation. When covered health care services are provided by Non-Participating health care Providers, the amount You pay for such services will generally be based on either the Host Blue's Non-Participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  Exceptions. In certain situations, We may use other payment bases, such as billed covered Charges, the payment We would make if the health care services had been obtained within Our network, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by Non-Participating health care Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's services will be considered Non-Participating Provider care, and You may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on Your ID card or go to www.geo-blue.com for more information about such arrangements.

Providers available to You through the BlueCard Program have not entered into contracts with 4 Ever Life Insurance Company. If You have any questions or complaints about the BlueCard Program, please call Us at the customer service telephone number listed on Your ID card.

We, or Our authorized Administrator, will provide written notice to the insured Participant within a reasonable period of time of any Participating Provider's r or breach of, or inability to perform under, any Provider contract, if We determine that the insured Participant or his/her insured Dependents may be materially and adversely affected, and provide the insured Participant with a current list of Participating Providers.

If the insured Participant needs a new Provider listing for any other reason, he/she may call the customer service telephone number listed on the ID card or go to www.geo-blue.com for a new Provider listing.

International/Foreign Country Providers
If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, Covered Expenses for these Foreign Country Providers are based on the Maximum Reimbursable Charge, if applicable, which may be less than actual billed Charges. Foreign Country Providers can bill the Covered Person for amounts exceeding Covered Expenses. GeoBlue provides a list to Covered Persons of Foreign Country Providers with whom GeoBlue has contracted to accept assignment of claims and direct payments from Us or Our Administrator for Covered Expenses incurred by Covered Persons, thus alleviating the necessity of the Covered Person paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are not Participating Providers, but rather a group of Foreign Country Providers for whom GeoBlue is able to provide background information and to arrange access for Covered Persons.

Special Plan Provisions

Services Available in Conjunction With Your Medical Plan
The following pages describe helpful services available in conjunction with Your medical Plan. You can access these services by calling the toll-free number shown on the back of Your ID card.

Case Management
Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Outpatient, or an Inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, Mental Health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, Your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on Your ID card. In addition, Your Employer, a claim office or a Utilization Review program (see the PAC/CSR section of Your Certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or Your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if You do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with You, Your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed;
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between Us, the patient, his or her family and Physician as needed (for example, by helping You to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Certification Requirements and Pre-Authorization

Certification Requirements – U.S. Providers

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when You or Your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization at a Skilled Nursing Facility, Rehabilitation Hospital and/or Sub-Acute Facility or Residential Treatment Facility.

You or Your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, You should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, You should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this Plan for the Charges listed below will not include any Hospital Charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a Utilization Review program by a Review Organization with which 4 Ever Life and its Administrator have contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the "Coordination of Benefits" section.

Prior Authorization/Pre-Authorized
The term Prior Authorization means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Certificate.

Services that require Prior Authorization include:
- Inpatient Hospital services, except for 48/96 hour maternity stays;
- Inpatient services at any participating Other Health Care Facility;
- residential treatment;
- Outpatient facility services;
- intensive Outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance;
- comprehensive Infertility services;
- bariatric surgery;
- compound and specialty drugs;
- transgender services; or
- transplant services.

Retrospective Review
If neither pre-service review, admission review nor continued stay review were performed, We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.

II. Who is Eligible for Coverage?

This section of Your Certificate describes who is eligible for coverage. We will use Our expertise and judgment to reasonably construe the terms of this Certificate as they apply to Your eligibility for benefits.

Participant Eligibility
To be a Participant under this Plan, You must meet all of the following requirements:
1. You are in a Class of eligible Participants; and
2. You have completed the waiting period; and
3. You pay any required contribution.

Waiting Period
For initial Participant Group: None

For new Participants: 1st day of the month following eligibility for the Plan

Classes of Eligible Participants
The following Classes of Participants are eligible for this insurance:
1. All Expatriates Participants
2. All Inpatriate Participants
3. All Third Country Nationals

"Expatriate" means an eligible Participant who is working or engaged in the conduct of the Group's business outside of the United States for a period of at least 180 days in a consecutive 12 month period that overlaps with the Plan year.

"Inpatriate" means an eligible Participant who is a citizen of another country other than the United States whose skills, qualifications, job duties, or expertise is of a type that has caused his or her Employer or sponsor to transfer or assign him or her to the United States for a specific and temporary purpose or assignment tied to his or her employment or engagement in the conduct of the Group's business.

"Third Country National" generally means a Participant who works or is located outside his or her country of citizenship, and outside the Group's country of domicile.

The Participant normally works or is engaged in the Group's business at least 30 hours a week.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this Plan.

Effective Date of Participant Insurance
You will become insured on the date You elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date You become eligible.

You will become insured on Your first day of eligibility, following Your election, if You are in Active Service on that date, or if You are not in Active Service on that date due to Your health status.

Late Entrant – Participant
You are a Late Entrant if:
- You elect the insurance more than 30 days after You become eligible; or
- You again elect the insurance after You cancel Your payroll deduction (if required).

If You do not elect coverage upon becoming eligible or within 30 days of becoming eligible You will be considered a Late Entrant for other than a special enrollment period. You must wait until the Group's next open enrollment period to enroll, except as provided below.

Dependent Insurance

Eligibility for Dependent Insurance
You will become eligible for Dependent insurance on the later of:
- the day You become eligible for Yourself; or
- the day You acquire Your first Dependent.

For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance
Insurance for Your Dependents will become effective on the date You elect it by signing an approved payroll deduction form (if required), but no earlier than the day You become eligible for Dependent Insurance. All of Your Dependents as defined will be included.

Your Dependents will be insured only if You are insured.

Late Entrant – Dependent
- You are a Late Entrant for Dependent Insurance if: You elect the insurance more than 30 days after You become eligible for it; or
- You again elect insurance after You cancel Your payroll deduction (if required).

A Dependent Spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

If You do not elect coverage upon becoming eligible for Dependent insurance or within 30 days of becoming eligible for Dependent insurance You will be considered a Late Entrant for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

Exception for Newborns
Coverage will be automatic from the moment of birth for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth. Notification of the Newborn Child's birth and the payment of any additional premium required to make coverage effective must be made within no less than thirty (30) days of the day of birth to make coverage effective from the moment of birth. Newborn Children will include a newly born infant adopted by You provided that:
- You take physical custody of the infant upon the infant's release from the Hospital; and
- You file a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and
- no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked.

Eligibility for Coverage for Adopted Children Other than Newborn Children
Your adopted child is automatically covered for Sickness or Injury for 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. A proposed adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.

To continue coverage beyond 31 days, You must enroll the adopted child within 31 days from either the date of placement or the final decree of adoption before the end of the waiting period. Notification of the adoption and the payment of any additional premium required to make coverage effective must be made during the waiting period to make coverage effective from the date of placement with You.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section above that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with You for adoption.

Step Children
Your step child is automatically covered for Sickness or Injury on the same basis as a natural child beginning on the day You assume financial responsibility for the support of such child. Notification of the step child becoming a dependent of Yours and the payment of any additional premium required to make coverage effective must be made within 31 days to make coverage effective from the day You assume financial responsibility.

Special Enrollment Period
You, and Your Spouse or child can also enroll for coverage within 30 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or child are no longer eligible for coverage under the other health plan due to:

- Termination of employment;
- Termination of the other health plan;
- Death of the Spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions toward a health plan were terminated; or
- A Child no longer qualifies for coverage as a Child under another health plan.

You, Your Spouse or child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage. We must receive notice and Premium payment within 30 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, and Your Spouse or child, can also enroll for coverage within 60 days of the occurrence of one of the following event:

- You or Your Spouse or child loses eligibility for Medicaid or a state child health plan.
- You or Your Spouse or child become eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

When Coverage Begins

Coverage under this Certificate will begin as follows:

- If You, the member, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Policyholder.
- If You, the member, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Policyholder's next open enrollment period to enroll, except as provided below.
- If You, the member, marry while covered, and We receive notice of such marriage within 30 days thereafter, coverage for Your Spouse starts on the first day of the month following such marriage. If We do not receive notice within 30 days of the marriage, You must wait until the Policyholder's next open enrollment period to add Your Spouse.
- If You, the member, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

III. When Does Coverage End?

Events That End Coverage
Coverage will end without notice, except as specified under "Medical Benefits Extension," on the last day of the month in which one of these events occurs:

- For the Participant and Dependents when:
  - The Group Policy is terminated;
  - The next monthly premium is not paid when due or within the grace period;
  - The Participant dies or is otherwise no longer eligible as a Participant;
  - In the case of a collectively bargained Plan, the Employer fails to meet the terms of an applicable collective bargaining agreement or to employ Employees covered by a collective bargaining agreement.
- For a Spouse when his or her marriage to the Participant is annulled, or when he or she becomes legally separated or divorced from the Participant, or for a Domestic Partner upon termination of the Domestic Partnership arrangement.
- For a child when he or she cannot meet the requirements for Dependent coverage shown under the "Who Is Eligible For Coverage?" section.

The Participant must promptly notify the Employer when a Dependent is no longer eligible to be enrolled as a Dependent under this Plan. The Employer must give Us written notice of a Covered Person's termination within 30 days of the date the Employer is notified of such event.

Temporary Layoff or Leave of Absence
If Your Active Service ends due to temporary layoff or leave of absence, Your insurance will be continued until the date the Employer (a) stops paying premium for You; or (b) otherwise cancels Your insurance. However, Your insurance will not be continued for more than 60 days past the date Your Active Service ends.

Injury or Sickness
If Your Active Service ends due to an Injury or Sickness, Your insurance will be continued while You continuously remain Totally Disabled as a result of the Injury or Sickness. However, Your insurance will not continue past the date the Employer stops paying premium for You or otherwise cancels Your insurance.

Policy Termination
No rights are vested under this Plan. Termination of the Group Policy for this Plan completely ends all Covered Persons' coverage and all of our obligations, except as provided under "Medical Benefits Extension"; please see the "How Do I Continue Coverage?" section below.

The Policy is guaranteed renewable. However, this Plan will automatically terminate if premiums are not paid within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid. This Plan may also terminate as indicated below.

The Group may terminate the Group Policy:

- Effective on any premium due date, upon 30 days' advance written notice, subject to the Grace Period.
- By rejecting in writing the Policy changes We make after the initial term. The written rejection must reach Us at least 15 days before the changes are to start. The Group Policy will end on the last date for which premiums were paid.

We may terminate the Group Policy, upon 45 days advance written notice to the Group due to:

1. non-payment of premium, subject to the Grace Period;

2. on the date of fraud or intentional misrepresentation of a material fact by the Group, except as indicated in the Time Limit on Certain Defenses provision;

3. on any premium due date for any of the following reasons. We must give the Group written notice of at least 30 days in advance if termination is due to:
   a. failure to maintain the required minimum premium contribution;
   b. failure to provide required information or documentation related to the Group Health Benefit Plan upon request;
   c. failure to maintain status as a Group as defined in the Definitions (Section III) provision.

   Coverage terminated pursuant to this item 3 shall be done uniformly without regard to any health status-related factor relating to any Covered Person.

   The date that the Policyholder's Policy is terminated. If We terminate and/or decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Policyholder and You at least 90 days' prior written notice.

4. on any premium due date if We are also canceling all Group Health Benefit Plans in the state or in a geographic service area. We must provide written notice to each Group and to all Insured Participants of such discontinuance at least 180 days prior to the date of discontinuance of such coverage. This written notice shall conspicuously include an explanation of each Insured Participant continuation and conversion rights and, also include the following information:
   a. a statement that if the New York Superintendent of Insurance (Superintendent) determines that You have a serious medical condition and has, within the previous twelve months utilized a benefit under the Certificate related to the serious medical condition that is not covered by the replacement coverage offered to the policyholder as a result of the discontinuance, then the Superintendent shall require Us to offer the policyholder replacement coverage that includes a benefit that is the same as or substantially similar to the benefit set forth in the policy that We discontinued; and
   b. an explanation as to how to contact the Superintendent, and the date by which the Superintendent shall be contacted, if the Policyholder or Group believes that the Covered Person has a serious medical condition, and the Covered Person within the previous twelve months utilized a benefit related to the serious medical condition that may not be covered by the replacement coverage offered to the policyholder as a result of the discontinuance; and
   c. We will offer to each Group the options any other Hospital, surgical and medical expense coverage currently being offered by Us to a group in such market.

5. You may terminate this Certificate at any time by giving Us at least 30 days' prior written notice.

Continuation (groups that employ fewer than 20 people)

If federal COBRA requirements do not apply to the Employer group, including for groups under 20 and upon application of the Employee or member to continue Hospital, surgical or medical expense insurance for himself or herself and his or her eligible Dependents. An Employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the Employee is sent notice by first class mail of the right to continuation by the group. The Employer group may charge an additional 2% administrative fee for continued coverage.

The continuation benefits terminate:

- The date 36 months after the date Your coverage would have terminated because of termination of Employment;
- In the case of a covered Spouse, Domestic Partner or child, the date 36 months after coverage would have terminated due to Your death, divorce or legal separation, Your eligibility for Medicare, or the failure to qualify under the definition of "children";
- The date You become covered by an insured or uninsured arrangement that provides group Hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date which the Employee or member becomes covered by an insured or uninsured arrangement which provides Hospital, surgical or medical coverage;
- The date to which premiums are paid if You fails to make a timely payment; or
- The date the Certificate or contract terminates. However, if the Certificate or contract is replaced with similar coverage, You have the right to become covered under the new Certificate or contract for the balance of the period remaining for Your continued coverage.

Continuation of Coverage

Qualifying Events

You, and Your Spouse and Your covered Dependent children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

- If Your coverage ends due to Your termination You may continue coverage. Coverage may be continued for You, and Your Spouse and any of Your covered Dependent Children.
- If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
  - Termination of the Covered Person';
  - Divorce or legal separation from the Covered Person or their Death.
- If You are a covered Dependent Child, You may continue coverage if Your coverage ends due to:
  - Termination of the Covered Person;
  - Loss of Dependent Child status under the plan rules; or
  - Death of Covered Dependent.

If You want to continue coverage, You must request continuation from Us in writing and make the first Premium payment within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date You are sent notice by first class mail of the right of continuation by the Policyholder.

Continued coverage under this section will terminate at the earliest of the following:

- The date 90 days after the Student's coverage would have terminated because of termination of Student status;
- If You are a covered Spouse or covered Dependent child, the date 90 days after coverage would have terminated due to Your death, divorce or legal separation, Your eligibility for Medicare, or the failure to qualify under the definition of "Dependent";
- The date You become covered by an insured or uninsured arrangement that provides hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or
- The date the Policy terminates. However, if the Policy is replaced with similar coverage, You have the right to become covered under the new Policy for the balance of the period remaining for Your continued coverage.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion section of this Certificate for Your right to conversion to an individual Policy.

Conversion
If a covered Employee under the group contract ceases to be covered because of termination of coverage because of:

- termination for any reason of his employment; or
- termination for any reason whatsoever of the group Policy or contract itself, unless the group Policy or contract holder has replaced the group Policy or contract with similar and continuous coverage for the same group, such Employee shall be entitled to a new Policy or contract as a direct pay member, covering such member and his eligible dependents.

Conversion is also available, upon the death of the Employee, to the surviving Spouse and Dependents, and the former Spouse of the Employee upon the divorce or annulment of the marriage to the Employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates.

The Employee or his eligible Dependents must request conversion by contacting Us within 60 days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage that covers all benefits required by state and federal law. The Employee or his eligible Dependents must also pay the first premium of the new contract at the time they apply for coverage.

Suspension of Coverage During Periods of Active Duty
If You are a member of a reserve component of the armed forces of the United States, including the National Guard, You will be entitled, upon written request, to have Your coverage suspended during a period of active duty as described in this provision. We will refund any unearned premiums for the period of such suspension.

Upon termination of a period of active duty of no longer than 5 years, the You will be entitled to resumption of coverage, upon written application and payment of the required premium within sixty days after the date of termination of the period of active duty. No limitations or conditions will be imposed as a result of such period of active duty except as set forth herein. Coverage will be retroactive to the date of termination of the period of active duty. Such right of resumption provided for herein will be in addition to other existing rights granted pursuant to state and federal laws and regulations and will not be deemed to qualify or limit such rights in any way.

No exclusion or waiting period will be imposed in connection with coverage of a health or physical condition unless:

- the condition arose during the period of active duty and has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or
- a waiting period was imposed and had not been completed prior to the period of suspension; in no event, however, shall the sum of the waiting periods imposed prior to and subsequent to the period of suspension exceed the length of the waiting period originally imposed.

To be entitled to this right, You must be a member of a component of the armed forces of the United States, including the National Guard, who either:

- voluntarily or involuntarily entered upon active duty (other than for the purpose of determining his or her physical fitness and other than for training), or
- has active duty voluntarily or involuntarily extended during a period when the President is authorized to order units of the ready reserve or members of a reserve component to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
- serves no more than five years of active duty.

The Dependent Medical Insurance will be continued until the earlier of:

- the date Your insurance ceases;
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

Your Employer may require You to pay the entire cost of the medical premium for You and Your Dependents, if covered, during the continuation period.

See Your Employer for additional information and to complete the required Medical Continuation Election Form. You must complete and return this form to Your Employer within 31 days of the date You cease employment.

Right of Young Adults through Age 29 to Elect Coverage:
Your Dependent child may be eligible to purchase his or her own coverage through this Certificate through the age of 29 if he or she:

- is unmarried;
- is under the age of 30;
- is not insured by or eligible for coverage under an Employer-sponsored health benefit plan covering him or her as an Employee or member, whether insured or self-insured;
- lives, works or resides in New York State or Our service area; and
- is not covered by Medicare.

The child may purchase coverage even if he or she is not chiefly dependent for maintenance and support on his or her parent(s) and does not need to live with his or her parent(s).

Your child may elect this coverage:

- Within sixty (60) days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
- Within sixty (60) days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within thirty (30) days of when the Group contract holder or Group contract holder's designee receives notice of election and premium payment;
- During the Annual Open Enrollment Period, in which case coverage will be prospective and will start within thirty (30) days of when the group contract holder or group contract holder's designee receives notice of election and premium payment; and
- During an initial 12-month open enrollment period, commencing on the first renewal of the Policy on or after the Policy Effective Date in which case coverage will be prospective and start within thirty-one (31) days of when the group contract holder or group contract holder's designee receives notice of election and premium payment.

If You elect to continue coverage for the child as an eligible Dependent, this provision does not apply. A child may have coverage under one option or the other.

Unmarried Students on Medical Leave
For Your Dependent children who are full time students to a higher age than other Dependent children, coverage will continue when such Dependent takes a medical leave of absence from school due to Sickness or Injury for a period of 12 months from the last day of attendance at school, provided that the coverage of the Dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We require that the Medical Necessity of the leave by certified to by the Dependent student's attending Physician.

Rescissions
A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Policy or was no longer eligible for coverage. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If an individual's coverage is going to be rescinded, the individual will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered an Adverse Benefit Determination that can be appealed according to the rules described in this Certificate.

Extension of Benefits
When Your coverage under this Certificate ends, benefits stop. But, if You are Totally Disabled on the date the Group Policy terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the Injury or Sickness that is the cause of the Total Disability.

When You May Continue Benefits
When Your coverage under this Certificate ends, We will provide benefits during a period of Total Disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the Injury, Sickness, or pregnancy causing the Total Disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of Total Disability for up to 12 months from the date Your coverage ends for covered services to treat the Injury, Sickness, or pregnancy that caused the Total Disability, unless these services are covered under another group health plan.

Limits on Extended Benefits
We will not pay extended benefits:
- For any Covered Person who is not Totally Disabled or pregnant on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Termination of Extension of Benefits
Extended benefits will end on the earliest of the following:
- The date You are no longer Totally Disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

Limits on Extended Benefits
We will not pay extended benefits:
- For any Cover Person who is not Totally Disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

Important Information About Your Medical Plan
Details of Your medical benefits are described on the following pages.

IV. Schedule of Benefits

This section of the Certificate explains the types of expenses You must pay for covered services before the benefits of this Plan are provided. To prevent unexpected Out-of-Pocket Expenses, it is important for You to understand what You are responsible for.

Coinsurance
The term Coinsurance means the percentage of Charges for Covered Expenses that a Covered Person is required to pay under the Plan.

Copayments/Deductibles
Copayments, or Copays, are expenses to be paid by You or Your Dependent for covered services. Deductibles are also expenses to be paid by You or Your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached, You and Your family need not satisfy any further medical Deductible for the rest of that year.

If the cost of the covered services is less than the Deductible, Copayments and/or Coinsurance for the covered service You are responsible for the lesser amount.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are Covered Expenses incurred for Charges that are not paid by the benefit Plan. The following expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached, they are payable by the benefit Plan at 100%:

- Coinsurance

The following Out-of-Pocket Expenses and Charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit Plan at 100% when the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached:

- Deductible
- Copayments
- Prescription Drug Copayments
- Provider Charges in excess of the Maximum Reimbursable Charge.
- Non-compliance penalties, if any, for failure to follow any Certification requirements or Pre-Authorization requirements.
- Non-Covered Expenses.
- Premiums or contributions.

Accumulation of Deductibles and Out-of-Pocket Maximums
Deductibles and Out-of-Pocket Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

Multiple Surgical Reductions
Multiple and/or bilateral surgical services rendered by the same professional Provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50%.

Procedures performed in conjunction with the primary surgical procedure considered by Us to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures are defined as procedures requiring little additional Provider resources and/or are clinically integral to the performance of the primary procedure.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to Charges made by an assistant surgeon as specified in 4 Ever Life or its Administrator's reimbursement policies.

Co-Surgeon
The maximum amount payable will be limited to Charges made by Co-Surgeons as specified in 4 Ever Life or its Administrator's reimbursement policies.

SCHEDULE OF BENEFITS

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
The Percentage of Covered Expenses the Covered Person Pays	10% Coinsurance	10% Coinsurance	10% Coinsurance of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the Provider's normal charge for a similar service or supply; or a percentage of Charges made by Providers of such service or supply in the geographic area where the service is received. These Charges are compiled in a database We have selected. **Note:** The Provider may bill You for the difference between the Provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and Coinsurance.			
Policy Year Deductible			
Individual	$0	$0	$0
Family Maximum	$0	$0	$0
Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.			
Out-of-Pocket Maximum			
Individual	$1,000	$1,000	$1,000
Family Maximum	2.5 times the individual Out-of-Pocket Maximum	2.5 times the individual Out-of-Pocket Maximum	2.5 times the individual Out-of-Pocket Maximum
Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.			
Physician's Services			
Physician's Office Visit - Primary Care Physician	10% Coinsurance	10% Coinsurance	10% Coinsurance
Office Visit – Specialist	10% Coinsurance	10% Coinsurance	10% Coinsurance
Surgery Performed In the Physician's Office	10% Coinsurance	10% Coinsurance	10% Coinsurance
Second Opinion Consultations (provided on a voluntary basis)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Allergy Treatment/Injections	10% Coinsurance	10% Coinsurance	10% Coinsurance
Preventive Care	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance, No Copay
Routine Preventive Care – all ages			
Immunizations – all ages	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance, No Copay

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance, No Copay
Lead Poisoning Screening Tests For Children under age 6	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 0% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance, No Copay
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Visits/Consultations	10% Coinsurance	10% Coinsurance	10% Coinsurance
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Services at Other Heath Care Facilities			
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	10% Coinsurance	10% Coinsurance	10% Coinsurance
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	10% Coinsurance	10% Coinsurance	10% Coinsurance
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Emergency and Urgent Care Services			If true emergency, the benefit will be paid at the U.S. Participating Provider Rate.
Hospital Emergency Room	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Professional Services (radiology, pathology and ER Physician)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Urgent Care Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	10% Coinsurance	10% Coinsurance	10% Coinsurance
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Ambulance	10% Coinsurance	10% Coinsurance	10% Coinsurance
Laboratory and Radiology Services (includes Pre-Admission Testing)			
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Independent X-ray and/or Lab Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Independent Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	10% Coinsurance	10% Coinsurance	10% Coinsurance
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Office visits in addition to the global maternity fee	10% Coinsurance	10% Coinsurance	10% Coinsurance
Laboratory, Radiology Services and or Advance Radiological Imaging	10% Coinsurance	10% Coinsurance	10% Coinsurance
Delivery Charges – Facility (Hospital, Birthing Center)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Services of a Doula	10% Coinsurance	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	10% Coinsurance	10% Coinsurance	10% Coinsurance
Elective	10% Coinsurance	10% Coinsurance	10% Coinsurance
Infertility Expenses – Basic			
Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of Infertility.			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Infertility Expenses – Comprehensive			
Limited Benefit – See benefit description for specific coverages and exclusions. Pre-authorization is required			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Family Planning /Reproductive Health Services See benefit description for specific coverages			
For Women			
Physician's Office Visit	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	10% Coinsurance
Inpatient Facility	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	10% Coinsurance
Outpatient Facility	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	10% Coinsurance
Physician's Services	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	You Pay 10% Coinsurance not subject to Plan Deductible or Copayments	10% Coinsurance
For Men			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Obesity/Bariatric Surgery Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Organ Transplant Services Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Transgender Services See benefit description for covered services. Pre-authorization is required			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Nutritional Evaluation			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Nutritional Formulas	10% Coinsurance	10% Coinsurance	10% Coinsurance
Acupuncture Physician's office visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Chiropractic Care/Spinal Manipulations Physician's office visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Annual Physical /Executive Health Screening for Services not covered as Preventive Care	10% Coinsurance	10% Coinsurance	10% Coinsurance
Telehealth	10% Coinsurance	10% Coinsurance	10% Coinsurance
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an Injury			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
TMJ Treatment	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Diabetic Equipment, Supplies and Self-Management and Education	10% Coinsurance	10% Coinsurance	10% Coinsurance
Durable Medical Equipment	10% Coinsurance	10% Coinsurance	10% Coinsurance
External Prosthetic Appliances	10% Coinsurance	10% Coinsurance	10% Coinsurance
Wigs (for hair loss due to alopecia areata or cancer treatment)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Mental Health (will be paid at the same level of coinsurance as any other illness/injury)			
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
ABA Treatment for Autism Spectrum Disorder (Pre-authorization required)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Assistive Communication Devices for Autism Spectrum Disorder (Pre-authorization required)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Psycho-Educational Testing	10% Coinsurance	10% Coinsurance	10% Coinsurance
Substance Use Health (will be paid at the same level of coinsurance as any other illness/injury)			
Inpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Hearing Benefit One Examination per 12 month period	10% Coinsurance	10% Coinsurance	10% Coinsurance
Hearing Aid Benefit A necessary hearing aid unit for each hearing impaired ear every 36 months	10% Coinsurance	10% Coinsurance	10% Coinsurance
Home Health Care Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Private Duty Nursing (40 visits per calendar year or continuous twelve-month period).	10% Coinsurance	10% Coinsurance	10% Coinsurance
Hospice Care Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Infusion Therapy			
Outpatient Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance
Physician's Services	10% Coinsurance	10% Coinsurance	10% Coinsurance
Short Term Rehabilitative Therapy			
Physician's Office Visit	10% Coinsurance	10% Coinsurance	10% Coinsurance
Outpatient Hospital Facility	10% Coinsurance	10% Coinsurance	10% Coinsurance

Prescription Drugs **Schedule of Benefits**
The below section describes the coverage for Prescriptions Drugs for You and Your insured Dependents. The Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the Schedule of Benefits and as described in the Prescription Drug Coverage section of this Certificate. To receive Prescription Drug Benefits, You and Your Dependents may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments. Your Cost Sharing will never exceed the Usual and Customary Charge of the Prescription Drug. Benefits are limited as described in the Prescription Drug section of this Certificate and are subject to the Medical "Exclusions" section of this Certificate.
The following are applicable to all Prescription Drug benefits:
• The Prescription drug designation is as per generally-accepted industry sources and adopted by Us and is subject to change

Prescription Drugs Purchased Outside of the United States	
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply	
Generic Drugs	10% Copayment per Prescription or refill.
Preferred Brand Drugs	10% Copayment per Prescription or refill.
non-Preferred Brand Drugs	10% Copayment per Prescription or refill.
Mail Order Prescription Drugs using Our mail order Prescription Drug vendor – Copayments based on a one (3) month supply	
Generic Drugs	10% Copayment per Prescription or refill.
Preferred Brand Drugs	10% Copayment per Prescription or refill.
non-Preferred Brand Drugs	10% Copayment per Prescription or refill.

Prescription Drugs Purchased Inside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
	Participating Retail Pharmacy	**Non Participating Retail Pharmacy**
Generic Drugs	10% Copayment per Prescription or refill.	10% Copayment per Prescription or refill.
Preferred Brand Drugs	10% Copayment per Prescription or refill.	10% Copayment per Prescription or refill.
non-Preferred Brand Drugs	30% Coinsurance per Prescription or refill. The Maximum Copayment per 1 month supply is $150.	30% Coinsurance per Prescription or refill. The Maximum Copayment per 1 month supply is $150.
Mail Order Prescription Drugs using Our mail order Prescription Drug vendor – Copayments based on a one (3) month supply		
	Participating Provider Mail Order Pharmacy	**Non-Participating Mail Order Pharmacy**
Generic Drugs	10% Copayment per Prescription or refill.	**Not Covered**
Preferred Brand Drugs	10% Copayment per Prescription or refill.	**Not Covered**
non-Preferred Brand Drugs	30% Coinsurance per Prescription or refill. The Maximum Copayment per 3 month supply is $450.	**Not Covered**

V. Covered Expenses Benefit Description

This section of Your Certificate describes the specific benefits available for covered services. Benefits, subject to the Copayments, coinsurance, Deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered Sickness, disease or Injury;
- It must be Medically Necessary (please see the "Definitions" section in this Certificate) and must be furnished in a Medically Necessary setting. Inpatient care is only covered when You require care that could not be provided in an Outpatient setting without adversely affecting Your condition or the quality of care You would receive;
- It must not be excluded from coverage under this Plan;
- The expense for it must be incurred while You are covered under this Plan and after any applicable waiting period required under this Plan is satisfied;
- It must be furnished by a Provider (please see the "Definitions" section in this Certificate) who is performing services within the scope of his or her license or certification;
- It must meet the standards set in Our medical and payment policies. Our medical and payment policies are used to administer the terms of the Plan. Medical policies are generally used to determine if a Covered Person has coverage for a specific procedure or service. Payment policies define billing and Provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA).

Benefits for some types of services and supplies may be limited or excluded under this Plan. Please refer to the actual benefit provisions throughout this section and the "Exclusions, Expenses Not Covered and General Limitations" section for a complete description of covered services and supplies, limitations and exclusions. **Any applicable Copayments, Deductibles or limits are shown in the Schedule of Benefits.**

Covered Expenses

- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an Outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of Charges which are in excess of the Other Health Care Facility Daily Limit shown in the Schedule of Benefits.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of Your family or Your Dependent's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic X-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Department of Health and Human Services.
- Charges made for children from birth through age 19 for immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; haemophilus influenzae B; and hepatitis A, and any new vaccines recommended by United States Preventive Task Force Services.
- Charges made for U.S. FDA approved prescription contraceptive drugs and devices and for Outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.

- Scalp hair prostheses worn due to alopecia areata or due to hair loss resulting from cancer treatment subject to the limits shown in the Schedule of Benefits.
- Colorectal cancer screening for persons 50 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of hereditary nonpolyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care Provider treating the Participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services after consideration of recommendations of the Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician, Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is Medically Necessary in the judgment of the treating Physician.
- Hearing aids for Dependent children up to age twenty-six (26).
- Nutritional formulas, low protein modified food products, or other medical food consumed or administered enterally (via tube or orally) which are Medically Necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a Physician.
- Charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.
- Charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- Charges for ostomy supplies for a covered condition.

Acupuncture
Benefits for acupuncture services received in a Provider's office when You see a Provider, are subject to the Copay and visit limitations as stated in the Schedule of Benefits. Benefits are provided for acupuncture services when Medically Necessary to relieve pain, induce surgical anesthesia, or to treat a covered Sickness, Injury, or condition.

Adult Annual Physical Examinations
We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the covered preventive services is available on Our website www.geo-blue.com or will be mailed to You upon request.

You are eligible for a physical examination once every Plan year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

Adult Immunizations
We cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

Ambulance Services
Benefits for the following services are subject to Your Policy Year Deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat Your condition, when any other mode of transportation would endanger Your health or safety. Medically Necessary Services and Supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for Your condition. This benefit only covers the Covered Person that requires transportation.

This coverage includes pre-Hospital Emergency Medical Services for the treatment of an Emergency Medical Condition when such services are provided by an ambulance service issued a certificate to operate pursuant to §3005 of the Public Health Law. For purposes of this benefit, Pre-Hospital Emergency Medical Services means the prompt evaluation and treatment of an Emergency Medical Condition, and/or non-air-borne transportation of the patient to the Hospital.

Coverage will be provided for transportation to a Hospital provided by an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

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

An ambulance service may not charge or seek reimbursement from You for pre-Hospital Emergency Medical Services except for the collection of any co-payment, Deductible or Coinsurance. We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable.

Ambulatory Care in a Hospital Out-Patient Facility
Ambulatory care in a Hospital out-patient facility includes:

- Surgery and any related Diagnostic Service received on the same day as the surgery
- services for diagnostic X-rays and MRIs;
- laboratory and pathological examinations;
- physical, occupational and radiation therapy;
- chemotherapy, including services and medications for non-Experimental cancer chemotherapy and cancer hormone therapy;
- radiation therapy;
- renal dialysis treatments – if received in a Hospital, a Dialysis Facility or in Your home under the supervision of a Hospital or Dialysis Facility
- Emergency Accident Care – treatment must occur within seventy-two (72) hours of the accident; and
- Emergency Medical Care.

Physical therapy services must be provided in connection for the same Sickness or Injury for which You had been Hospitalized or in connection with surgical care. However, coverage will not be provided if physical therapy services commence more than six (6) months after discharge from a Hospital or the date surgical care was rendered or after 365 days from the date of Hospital discharge or the date surgical care was rendered.

Ambulatory Care in a Physician's Office
Ambulatory care in a Physician's offices includes:

- diagnostic X-rays, radiation therapy, laboratory and;
- pathological examinations; and
- services and medications used for non-Experimental cancer chemotherapy and cancer hormone therapy.

Annual Physical/Executive Health Screening for Services not covered as Preventive Care
Benefits are provided up to the limit as shown in the Schedule of Benefit for medical services provided by a medical professional practicing within the scope of their licenses for an annual physical/executive health screening to cover labs and medical diagnostic tests recommended by the medical professional that are not covered under the Preventive Care benefits available to all Covered Persons

Autism Spectrum Disorder Benefit
We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder.

1. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

2. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

   We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

3. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

4. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

5. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

6. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

7. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

   You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

   Note: Visit limits do not apply to the treatment of autism.

   Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

   For purposes of this benefit, the following definitions apply:

   Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

   Assistive Communication Devices shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.

   Autism Spectrum Disorder
   Is any pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, at the time services are rendered.

   Behavioral Health Treatment means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a licensed or certified behavior analysis provider, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

Bone Mineral Density Measurements or Testing
We Cover benefits for Medically Necessary bone mineral density measurements or tests, and if the Certificate otherwise includes coverage for prescription drugs, drugs and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered and for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health.

Individuals qualifying for coverage, at a minimum, include individuals:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

Child Wellness Benefits
We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also Covered.

This benefit is provided to Dependents from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Chiropractic Care Services/Spinal Manipulations
We cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this Certificate.

Clinical Trials
This Plan covers routine patient care costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and external Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

The Plan covers:

- Charges made by a Physician, a Dentist and Hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) for surgery needed to:
  - Treat a fracture, dislocation or wound.
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of Your condition.
- General anesthesia and related facility services for dental procedures are covered when Medically Necessary for 1 of 3 reasons:
  - Covered Persons who are under 7 years of age;
  - Covered Persons who are developmentally disabled, regardless of age; or
  - Covered Persons whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - As a result of an Injury to natural teeth damaged, lost or removed; or
  - Other body tissues of the mouth fractured or cut due to Injury.
  - Any such teeth must have been free from decay or in good repair,and be firmly attached to the jaw bone at the time of the Injury.

- If crowns, dentures, bridges or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

Please Note: An Injury does not include damage caused by biting or chewing, even if due to a foreign object in food. The treatment must be completed within 12 months of the Injury.

Diabetes
Coverage is provided for equipment, supplies and self-management education for the treatment of diabetes.

Diabetic Equipment, Supplies and Self-Management Education
We cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies**
   We cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Blood glucose kit
   - Blood glucose strips (test or reagent)
   - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home
   - blood glucose monitor
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose reagent strips
   - Glucose reagent tape
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets
   - Oral agents such as glucose tablets and gels
   - Oral anti-diabetic agents used to reduce blood sugar levels
   - Syringe with needle; sterile 1 cc box
   - Urine testing products for glucose and ketones
   - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. Self-Management Education

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

Dialysis

We cover dialysis treatments of an Acute or chronic kidney ailment. We also cover dialysis treatment provided by a Non-Participating Provider subject to all of the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment;
- The Non-Participating Provider is located outside the service area;
- The Participating Provider treating You for the condition issues a written order stating that the dialysis treatment by the Non-Participating Provider is necessary;
- You notify Us in writing 30 days in advance of the proposed treatment date(s) and attach the written order referred to above. If You must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that We have a reasonable opportunity to review Your travel and treatment plans;
- We have the right to pre-approve the dialysis treatment schedule; and
- Such coverage will be limited to ten (10) Out-of-Network dialysis treatments per Covered Person in a calendar year.

Benefits for services of a Non-Participating Provider are subject to any applicable cost-sharing that applies to dialysis treatments by a Participating Provider. However, You are responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider's charge.

Durable Medical Equipment

Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Us for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Covered Person's misuse are the Covered Person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Utilization Review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Special or extra-cost convenience features;
- Structural modifications to Your home or personal vehicle;
- Air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities;
- Penile prostheses;
- Other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

Emergency Services

Coverage is provided for the treatment of an Emergency Medical Condition in Hospital facilities:

- Without the need for any prior authorization;
- Regardless of whether the Provider is a Participating Provider;
- Without imposing any administrative requirement or limitation on Out-of-Network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;
- The cost-sharing (co-payment or Coinsurance) shall be the same regardless of whether the services are provided by a Participating or a Non-Participating Provider; and
- The benefits for Out-of-Network Emergency Services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method We use to determine payments for Out-of-Network services excluding any in-network co-payment or Coinsurance; or the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or Coinsurance.

You shall be held harmless for any nonparticipating Provider charge for emergency services that exceeds the in-network copayment, Coinsurance or Deductible.

If a dispute involving a payment for Emergency Services provided by a Physician is submitted to an independent dispute resolution entity ("IDRE"), We must pay the amount, if any, determined by the IDRE for Physician services.

End of Life Care

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will cover acute care provided in a licensed Article 28 Facility or acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an Expedited External Appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

- We will reimburse a rate that has been negotiated between Us and the Provider.
- If there is no negotiated rate, We will reimburse acute care at the Facility's current Medicare acute care rate.
- If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare acute care rate.

External Prosthetic Appliances and Devices
Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the Utilization Review Physician. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; splints; and medical vision hardware.

Prostheses/Prosthetic Appliances and Devices
Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement and from foot disfigurement caused by accident or developmental disability

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces
A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

Copes scoliosis braces are specifically excluded.

Splints
A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:
- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:
- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Medical Vision Hardware
Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

Family Planning and Reproductive Health Services
We cover family planning services which consist of FDA-approved methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not cover services related to the reversal of elective sterilizations.

Benefits for sterilization and for contraceptive management are covered as shown in the Schedule of Benefits. Coverage differences apply to men and women.

This benefit covers the following services and supplies received from a health care Provider:
- Office visits and consultations related to contraception;
- Injectable contraceptives and related services;
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable); and
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility Charges will be subject to Your cost-shares under the applicable facility benefit and are not covered by this benefit.

Contraceptives Dispensed By a Pharmacy

- Prescription contraceptives (including emergency contraception) and Prescription barrier devices or supplies that are dispensed by a licensed Pharmacy are covered under the Prescription Drugs benefit. For women, the normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when You get them from a Participating Pharmacy.

  Examples of covered devices are diaphragms and cervical caps.

- Over-the-counter female contraceptives that are prescribed by Your healthcare Provider and purchased through a licensed Pharmacy are also covered. No cost-share is required when You get them through a Participating Pharmacy.

The Contraceptive Management and Sterilization benefit does not cover:

- Over-the-counter male contraceptive drugs, supplies or devices;
- Prescription contraceptive take-home drugs dispensed and billed by a Provider's office;
- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.); or
- Testing, diagnosis, and treatment of Infertility, including fertility enhancement services, procedures, supplies and drugs;
- Reversal of male or female voluntary sterilization procedures;
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- A person has symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
- For Pregnancy and Maternity Care - Benefits are provided for participation in the Expanded Alpha Feto Protein (AFP) prenatal testing Program.
- For Prenatal Diagnosis of Genetic Disorders: Benefits are paid for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of High-risk Pregnancy. High-risk Pregnancy means a pregnancy in which some condition puts the mother, the developing fetus, or both at higher-than-normal risk for complications during or after the pregnancy and birth and must be classified as having one of the following risk factors:
  - Moderate to severe preeclampsia (toxemia);
  - Chronic hypertension;
  - Moderate to severe renal disease;
  - Severe heart disease (class II-IV);
  - Insulin-dependent diabetes;
  - Uterine malformation;
  - Incompetent cervix;
  - Polyhydramnios or oligohydramnios; or
  - Placenta previa.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 5 visits per calendar year for both pre- and post-genetic testing.

Habilitation Services.
We cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a facility or in a health care professional's office.

Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

Home Health Care Services
Home Health Care must be preauthorized.

Coverage is provided for home care for not less than 40 visits in any calendar year or continuous twelve month period for each person covered under the Certificate if Hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional Nurse.
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical, occupational or speech therapy if provided by the home health service or agency.
- Medical supplies, prescription drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency.
- Each visit by a member of a home care team shall be considered as one home care visit.
- Four hours of home health aide service shall be considered as one home care visit.

Home Health Care Limits
Unless specified above, not covered under this benefit are Charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with You, or who is a member of Your or Your Spouse's or Your Domestic Partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

The Plan does not cover Custodial Care, even if care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.

Refer to the Schedule of Benefits for details about any applicable Home Health Care visit maximums.

Benefits for Home Health Care visits are payable up to the Home Health Care Maximum. Each visit by a Nurse or therapist is one visit.

Hospice Care Services
Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the Hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the Hospice is located. We do not cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

The following Charges for Hospice Care Services are not included as Covered Expenses:
- for the services of a person who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house;
- for any period when You or Your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under this Certificate;
- for services or supplies that are primarily to aid You or Your Dependent in daily living.

Hospital Inpatient Care
We cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for a Sickness, Injury or disease of a severity that must be treated on an inpatient basis including:
- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

This benefit does not cover:
- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of Inpatient Hospital facilities, or unless Your medical condition makes Inpatient care Medically Necessary.
- Any days of Inpatient care that exceeds the length of stay that is Medically Necessary to treat Your condition.

In-Patient Stay for Mastectomy Care
Charges made for a period of inpatient Hospital care for undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

Infertility Services

Basic Infertility Expenses
Basic infertility services will be provided to a Covered Person who is an appropriate candidate for Infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, a Covered Person must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Basic Infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary. Covered Expenses include charges made by a Physician to diagnose and to surgically treat the underlying medical cause of Infertility.

Comprehensive Infertility Expenses
To be eligible for benefits You must be covered under the Plan as a Participant, or be a covered Dependent who is the Participant's Spouse or Domestic Partner.

If the basic Infertility services do not result in increased fertility, We Cover comprehensive infertility services. Comprehensive infertility services include:

- Ovulation induction and monitoring;
- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

Advanced Infertility Services.
We Cover advanced infertility services. Advanced infertility services include:

- In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs; and
- Cryopreservation and storage of embryos.

Advanced Reproductive Technology (ART) Benefits
ART is defined as:
- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers; and
- Intracytoplasmic sperm injection (ICSI); or
- ovum microsurgery.

To be eligible for ART benefits under this Plan, You must meet the requirements above and:
- First exhaust the comprehensive Infertility services benefits. Coverage for ART services is available only if comprehensive Infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by Your Physician to claims Administrator's Infertility case management unit;
- Obtain pre-authorization from claims Administrator's Infertility case management unit for ART services by an ART Specialist.

Covered ART Benefits
The following Charges are covered benefits for eligible covered females when all of the above conditions are met and the services are performed on an Outpatient basis, subject to the Medical Plan Exclusions section of the booklet:
- Up to three cycles and subject to the maximum benefit, if any, shown in Your Summary of Medical Benefits of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received) which only include: IVF; GIFT; ZIFT or cryopreserved embryo transfers;
- IVF; intracytoplasmic sperm injection (ICSI); ovum microsurgery; GIFT; ZIFT or cryopreserved embryo transfers subject to the maximum benefit shown in Your Summary of Medical Benefits while covered under the Plan;
- Payment for Charges associated with the care of an eligible Covered Person under this Plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the Spouse's or Domestic Partner's sperm for ART, when the Spouse or Domestic Partner is also covered under this Plan.

Infertility Exclusions and Limitations
Unless otherwise specified above, the following Charges will not be payable as Covered Expenses under this Plan:
- in vitro fertilization;
- gamete intrafallopian tube transfers;
- zygote intrafallopian tube transfers;
- the reversal of elective sterilizations;
- sex change procedures;
- cloning; or
- medical or surgical services or procedures determined to be experimental.

Infusion Therapy
Covered Expenses include Charges made on an Outpatient basis for Infusion Therapy if the rendering Provider's bill includes fees for both medication and administration and if the services are provided by:
- A free-standing facility;
- The Outpatient department of a Hospital; or
- A Physician in his/her office or in Your home.

When You obtain Infusion Therapy medications from a Pharmacy or if they are not billed by Your Provider along with the therapy administration fee, You should submit Your claims for medications under the Prescription Drug benefits, rather than the medical benefits.

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are a part of Your course of treatment. Charges for the following Outpatient Infusion Therapy services and supplies are Covered Expenses:

- The pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this Infusion Therapy benefit are Charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for Inpatient Infusion Therapy is provided under the Plan's Inpatient Hospital and Skilled Nursing Facility benefits.

Benefits payable for Infusion Therapy will not count toward any applicable Home Health Care maximums.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer

We cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for a Covered Person age 35 through 39; and
- One (1) screening mammogram annually for a Covered Person age 40 and over.

If a Covered Person of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We cover mammograms as recommended by the Covered Person's Provider. However, in no event will more than one (1) preventive screening per Plan year be covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

Maternity Care/Obstetrical Services

Benefits for pregnancy and childbirth are provided on the same basis as any other condition for the Participant or enrolled Spouse or enrolled Dependent child. Complications of pregnancy are covered on the same basis as any other Sickness for the Participant, enrolled Spouse, or enrolled Dependent child.

Preventive diagnostic services that meet the guidelines for preventive care are covered for all eligible Covered Persons as stated in the Preventive Care benefit.

- Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section.
- The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care.
- Maternity coverage also includes coverage of the services of a licensed midwife practicing consistent with a collaborative relationship with a Physician or a licensed Hospital.
- Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting or purchasing one (1) breast pump per pregnancy in conjunction with childbirth is covered in full.

Inpatient Hospital Services
Benefits for these services are shown in the Schedule of Benefits.

Birthing Center and Short-Stay Hospital Facility Services
Benefits for these services are shown in the Schedule of Benefits.

This benefit covers Inpatient Hospital, birthing center, Outpatient Hospital and emergency room services, including post-delivery care as determined necessary by the attending Provider, in consultation with the mother, based on accepted medical practice.

Group health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending Provider in consultation with the mother. In cases of adoption, coverage of the initial hospital stay will not be required where a birth parent has insurance coverage available for the infant's care.

The mother shall have the option to be discharged earlier than the time periods established above. We will cover one home care visit which shall be in addition to, rather than in lieu of, any home health care coverage otherwise available under the Certificate. The home care visit, which may be requested at any time within forty-eight hours of the time of delivery (ninety-six hours in the case of caesarean section), shall be delivered within the later of twenty-four hours after discharge, or of the time of the mother's request. The home care is not subject to a deductible or Coinsurance. Benefits are provided for care and treatment during pregnancy shall include provision for not less than two payments, at reasonable intervals and for services rendered, for prenatal care and a separate payment for the delivery and postnatal care provided.

Plan benefits are also provided for Medically Necessary supplies related to home births.

Benefits for the following obstetrical care services are covered as shown in the Schedule of Benefits.

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus. For genetic screen specifics, please see the Genetic Testing benefit described in this Certificate.
- Delivery, including cesarean section, in a medical facility, or delivery in the home.
- Postpartum care consistent with accepted medical practice that's ordered by the attending Provider, in consultation with the mother. Postpartum care includes services of the attending Provider, a home health agency and/or registered Nurse.
- Coverage for a Doula (a trained birth assistant) services in home or facility up to 10 visits (pre and post-natal combined).

Attending Provider as used in this benefit means a Physician (M.D. or D.O.), a Physician's assistant, a certified Nurse midwife (C.N.M.), a licensed midwife or an advanced registered Nurse practitioner (A.R.N.P.). If the attending Provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this Plan will cover those services as it would any other surgery. Please see the Schedule of Benefits for details.

As part of Your maternity benefits, certain services rendered to Your newborn infant are also covered These covered services are: a) the routine Inpatient Hospital nursery charges and b) one routine inpatient examination as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an Sickness or Injury, benefits will be available for that care only if you have family coverage. You may apply for family coverage within 31 days of date of the birth. Your family coverage will then be effective from the date of the birth.)

Mental Health and Substance Use Services
Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addition Equity Act of 2008.

A. Mental Health Care Services

1. Inpatient Services
We cover In-Patient Mental Health Care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health and, in other states, to similarly licensed or certified Facilities.

We also cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. Outpatient Services
We cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof.

3. **Limitations/Terms of Coverage.** We do not cover:
   - Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
   - Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services;
   - Services solely because they are ordered by a court; or
   - Family and marital counseling except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Covered Person.

B. Substance Use Services

1. **Inpatient Services -** We cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

   We also cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities that provide services defined in 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817; and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services** We cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial Hospitalization program services, intensive outpatient program services, and methadone treatment. Such coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

   We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same family Policy that covers the person receiving, or in need of, treatment for substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

Newborn Care
Newborn children are covered automatically for the first 31 days from birth when the mother is eligible to receive obstetrical care benefits under this Plan. To continue benefits beyond the 31 day period, please see the Dependent eligibility and enrollment guidelines outlined in the "Who Is Eligible For Coverage?" and "When Does Coverage Begin?" sections.

If the mother is not eligible to receive obstetrical care benefits under this Plan, the newborn is not automatically covered for the first 31 days. For newborn enrollment information, please see the "Who Is Eligible For Coverage?" section.

Plan benefits and provisions will apply, subject to the child's own applicable Copay, Policy Year Deductible and Coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending Provider in consultation with the mother.

Hospital Care
Benefits for these services are subject to Your Policy Year Deductible and Coinsurance when You use a facility.

The Newborn Care benefit covers Hospital nursery care as determined necessary by the attending Provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a Hospital and Outpatient or emergency room services for Medically Necessary treatment of a Sickness or Injury.

Group health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending Provider in consultation with the mother.

Professional Care
Benefits for services received in a Provider's office are subject to the terms of the Professional Visit benefit. Well-baby exams in the Provider's office are covered under the Preventive Care benefit. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that is ordered by the attending Provider, in consultation with the mother. Follow-up care includes services of the attending Provider, a home health agency and/or a registered Nurse.
- Circumcision

Inpatient Professional Care
Benefits for these services are subject to Your Policy Year Deductible and Coinsurance when services are provided by an attending Provider.

Outpatient Professional Visits
You pay the Copay as stated in the Schedule of Benefits per visit in an office setting when You use a Provider.

When You see a Provider outside an office setting, benefits are subject to Your Policy Year Deductible and Coinsurance.

Please Note: Attending Provider as used in this benefit means a Physician (M.D. or D.O.), a Physician's assistant, a certified Nurse midwife (C.N.M.), a licensed midwife or an advanced registered Nurse practitioner (A.R.N.P.).
This benefit does not cover immunizations and Outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and Outpatient well-baby exams.

Nutritional Evaluation
Charges made for nutritional evaluation and counseling when diet is part of the medical management of a documented organic disease.

Obesity Treatment
Covered Expenses include Charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of obesity for the following Outpatient weight management services:

- An initial medical history and physical exam; or
- Diagnostic tests given or ordered during the first exam

The Plan covers Inpatient or Outpatient Charges made by a Hospital or a Physician for the Medically Necessary surgical treatment of Morbid Obesity. Bariatric surgery must be approved in advance by claims Administrator.
Covered Expenses include one Morbid Obesity surgical procedure within a two-year period, beginning with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

The Plan does not cover

- medical and surgical services, intial and repeat, intended to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of Obesity or clinically severe (Morbid) Obesity; and
- bariatric surgery when done for cosmetic reasons; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Services Performed at Comprehensive Care Centers for Eating Disorders
Benefits will be provided for services otherwise covered under the Policy when provided by a comprehensive care center for eating disorders pursuant to New York Law. Services provided through such comprehensive care centers will, to the extent possible and practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.

Organ Transplant Services
The Transplants benefit is not subject to a separate benefit maximum other than the maximum for donor costs described below. This benefit covers medical services only if provided by Providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about Approved Transplant Centers.

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered Experimental or Investigational for the treatment of Your condition. (Please see the "Definitions" section in this Certificate for the definition of "Experimental/Investigational" services.) We reserve the right to base coverage on all of the following:

Organ transplants and bone marrow/stem cell reinfusion procedures must meet Our criteria for coverage.

We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet Our criteria for coverage are:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

For the purposes of this Plan, the term "transplant" does not include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

- Your medical condition must meet Our written standards.
- The transplant or reinfusion must be furnished in an Approved Transplant Center, (an "Approved Transplant Center" is a Hospital or other Provider that has developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by Us.) Whenever medically possible, We will direct You to an Approved Transplant Center that We have contracted with for transplant services.

If none of Our centers or the Approved Transplant Centers can provide the type of transplant You need, this benefit will cover a transplant center that meets written approval standards set by Us.

The following services are included in the Transplant Services benefits:

- **Inpatient Facility Services** – Benefits for services in a facility or an approved transplant center are subject to Your Policy Year Deductible and Coinsurance.

- **Inpatient Professional and Surgical Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Policy Year Deductible and Coinsurance.

- **Outpatient Surgical Facility Services** – Benefits for a facility or an Approved Transplant Center are subject to Your Policy Year Deductible and Coinsurance.

- **Outpatient Professional Visits** – You pay the Copay as stated in the Schedule of Benefits per visit in an office setting to a Provider or an approved transplant Provider. Please see the Schedule of Benefits section of this Certificate for details about the professional office visit Copay.

  When a professional visit is not provided in an office setting, benefits are subject to Your Participating Provider Policy Year Deductible and Coinsurance.

- **Other Outpatient Professional Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Policy Year Deductible and Coinsurance.

- **Recipient Costs** – This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the Inpatient or Outpatient stay in which the transplant was performed.

- **Donor Costs –** Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

This benefit does not cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that is not covered under this benefit, or for a recipient who is not a Covered Person.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless We determine they are not Experimental/Investigational services (please see the "Definitions" section in this Certificate).
- Personal care items.
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct provided:

- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the Utilization Review Physician.

Pap Smear Tests

Benefits will be provided for an annual routine Pap smear test for females aged 18 and older. This includes a cervical cytology screening and provides for an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating a Pap smear.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

Pre-Admission Testing

We cover preadmission testing ordered by Your Physician and performed in the outpatient facilities of a Hospital prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

Private Duty Nursing

Private duty nursing services must be preauthorized.

Covered Expenses include private duty nursing provided by an R.N. or L.P.N. if the Covered Person's condition requires skilled nursing care and visiting nursing care is not adequate. However, Covered Expenses will not include private duty nursing for any shifts during a policy year in excess of the Private Duty Nursing care visit limit. Each period of private duty nursing of up to eight hours will be deemed to be one private duty nursing shift.

The Plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in Your medication;
- Treatment of an urgent or Emergency Medical Condition by a Physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An Inpatient Hospital stay.

Private Duty Nursing Limits

Unless specified above, not covered under this benefit are Charges for:

- Nursing care that does not require the education, training and technical skills of an R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while You are an Inpatient in a Hospital or Health Care Facility, provided the care can adequately be provided by the facility's general nursing staff, if it were fully staffed.
- A service provided solely to administer oral medicine, except where law requires an R.N. or L.P.N. to administer medicines.

Prostate Cancer Screening

We cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is not subject to Copayments when provided by a Participating Provider.

Psycho-Educational Testing

Psycho-educational testing conducted by a licensed clinical, educational, or counseling Psychologist in order to assess and diagnose functional limitations due to learning disabilities, including, but not limited to, attention deficit hyperactivity disorder (ADHD). This benefit covers psycho-educational test batteries including aptitude, achievement, and cognitive tests to assess for cognitive and learning disabilities; a written report listing test scores, testing procedures followed, interpretation of test results, and date(s) of testing. Consultation with the student to review test results and recommendations for appropriate academic accommodation are also covered under this benefit.

Reconstructive Breast Surgery

We cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also cover implanted breast prostheses following a mastectomy or partial mastectomy.

Reconstructive Surgery
Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Utilization Review Physician.

Second Medical Opinion for Cancer Diagnosis
We provide coverage for a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

- This benefit includes coverage for a second medical opinion from a non-participating Specialist, including but not limited to a Specialist affiliated with a specialty care center for the treatment of cancer when the attending Physician provides a written referral to the non-participating Specialist, at no additional cost to You beyond what You would have paid for services from a participating Specialist.
- A second medical opinion by a non-participating Specialist where there is no referral from the attending Physician and where We have not pre-authorized the service. In such cases, We are responsible for covering the Medically Necessary services at a usual, customary and reasonable rate.

Second Surgical Opinion
Your coverage includes coverage for a second surgical opinion by a qualified Physician on the need for surgery.

Short-Term Rehabilitative Therapy
Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- Maintenance or Preventive Treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Non-medical counseling or ancillary services, including but not limited to Custodial Care services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, education therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.

Multiple Outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Surgical Services
We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and postoperative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

At times, two (2) or more surgical procedures can be performed during the same operation.

- **Through the Same Incision.** If covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest allowed amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

- **Through Different Incisions.** If covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
  - For the procedure with the highest allowed amount; and
  - 50% of the amount We would otherwise pay for the other procedures.

Oral Surgery
We cover the following limited dental and oral surgical procedures:
- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental Injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the Injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Telehealth
This Plan provides benefits for covered services that are appropriately provided through Telehealth, subject to the terms and conditions of the Plan. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Refer to the definition of Telehealth.

Telehealth does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine, or electronic mail.

Equipment costs and transmission costs associated with Telehealth are not reimbursable.

Temporomandibular Joint (TMJ) Disorders
Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under other benefits of this Plan.

This benefit includes coverage for Inpatient and Outpatient facility and professional care, including professional visits.

Medical and dental services and supplies are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good medical or dental practice.
- Not Experimental or Investigational, as determined by Us according to the criteria stated under "Definitions," or primarily for cosmetic purposes.

Transgender Services
Services and supplies provided in connection with gender transition when You have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of this Certificate that apply to all other covered medical conditions, including Medical Necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to the Certificate's benefits that apply to that type of service generally, if the Certificate includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Certificates Prescription Drug benefits.

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided.

Well-Woman Examinations
We cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the covered preventive Services is available on Our website at www.geo-blue.com, or will be mailed to You upon request.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

VI. Prescription Drug Benefits

Covered Expenses
If You or any one of Your Dependents, while insured for Prescription Drug Benefits, incurs expenses for Charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a practitioner licensed to prescribe, We will provide coverage for those expenses as shown in the Schedule of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

Administered by a Medical Provider
This Plan also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an Outpatient facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Participating Provider orders the Drug and administers it to You and is paid as a Medical Expense

Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Injectable Drugs) are covered under the Prescription Drug Benefits.

Conditions of Service
To be a covered service, the Prescription Drug or medicine must be:
- Prescribed in writing by a practitioner licensed to prescribe and dispensed within one Policy Year of being prescribed, subject to federal, state laws or local jurisdictional rules;
- To be a Covered Expense, the Prescription Drug or medicine must be prescribed for use within the approved package label for the drug and/or a recognized treatment for an indication in standard reference compendia or in the clinical literature. Any coverage for use outside of the approved package label shall also include Medically Necessary services associated with the administration of the drug;
- If purchased outside of the United States, the purchase and distribution is subject to the local laws and local jurisdictional responsibilities;
- For the direct care and treatment of the Covered Person's Sickness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included;
- Purchased from a licensed retail or mail order Pharmacy;
- Not prohibited by law.

Benefits are available for the following:
- Prescription Drugs from either a retail Pharmacy or Our mail order Pharmacy;
- Specialty Drugs;
- Self-Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectable and infused Drugs that need Provider administration and/or supervision are covered under the medical portion of this Plan by Medical Provider benefit;
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via feeding tube, for which a Physician or other licensed health care Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies;
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism;
- Self-injectable insulin and supplies and equipment used to administer insulin including syringes;
- Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;

- All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a practitioner licensed to prescribe (male contraceptive methods are not covered). This Plan covers at least one form of contraception in each of the methods identified by the FDA in its current Birth Control Guide including but not limited to oral, injectable, and implantable contraceptives, diaphragms, contraceptive patches and rings, and emergency contraceptives. In order to be covered as preventive care, contraceptive Prescription Drugs must be either a Generic or single-source Brand Drug (a single-source Brand Drug is a Drug for which there is no Generic equivalent), be prescribed by a practitioner licensed to prescribe, and obtained from a Participating Pharmacy. Multi-source Brand Drugs (those that have a Generic equivalent) will be covered as preventive care if Medically Necessary as determined by Your practitioner. Certain contraceptives are covered under the Plan's medical benefits. Please see that section in the part Covered Expenses Benefit Descriptions under the section "Preventive Care" for more details;
- Vaccinations including administration (ex. Influenza vaccines and others) that are able to be administered by pharmacists under applicable regulation;
- Appropriate pain management medications for terminally ill patients.
- Orally administered prescribed anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at Your option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.

Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment. If You have an Emergency Medical Condition, You may immediately access, without Preauthorization, a five (5) day emergency supply of a Covered Prescription Drug for the treatment of a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If You have a Copayment, it will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the emergency supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

In this paragraph, "Emergency Medical Condition" means a substance use disorder condition that manifests itself by Acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

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

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy may be subject to a Deductible, Copayment or Coinsurance. Please refer to the Schedule of Benefits for any required cost sharing or maximums if applicable. Your cost sharing will never exceed the Usual and Customary Charge of the Prescription Drug.

Off Label Cancer Drug Usage
Coverage for Prescription Drugs is provided for drugs being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

Limitations
Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 180-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 180-day supply at a mail order Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the Pharmacy &Therapeutics (P&T) Committee.

Eye Drops Limitation: You will have a right to a limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. Any refill dispensed prior to the expiration of the approved coverage period will, to the extent practicable, be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

The limitation will not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.

Definitions
To understand the Your Prescription Drug Benefits, it may be helpful to review these important terms:

Compound Drugs or Compound Medicines means a compounded prescription that is the result of mixing two or more drug ingredients into a final dosage form (tablet, capsule, liquid, suspension, cream, ointment, gel, etc.). The act of compounding is a practice in which a licensed pharmacist, a practitioner licensed to prescribe, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

Drugs (Prescription Drugs) means; a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; certain drugs approved under the FDA's Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

For purposes of this benefit, insulin is considered a Prescription Drug.

Fixed Dose Combination Drugs means manufactured fixed dose combination medicines that because of unique formulation characteristics permits market exclusivity for these medicines and single source brand drug status.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. Generally Generic Prescription Drugs are covered under as a Tier 1 drug.

Injectable Drug is a drug that can put into the body with a needle or syringe. The medicine is put under the skin, or into a vein.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with Us at the time services are rendered. The Covered Person will be responsible for a larger portion of the pharmaceutical bill when the Covered Person goes to a Non-Participating Pharmacy.

A **Non-Preferred Brand Name Prescription Drug** is one not included on the Plan's formulary or list of preferred prescriptions. Non-preferred Brand Name Prescription Drugs have a higher Coinsurance than Preferred Brand Name Prescription Drugs. You pay more if You use non-preferred drugs than if You opt for Generics and Brand Name Prescription Drugs. These drugs are generally covered as a Tier 3 drug.

Participating Pharmacy is a retail Pharmacy with which We or Our designee have contracted to provide prescription services to Covered Persons, or a designated home delivery Pharmacy with which We or Our designee have contracted to provide home delivery prescription services to Covered Persons. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Pharmacy means a licensed retail Pharmacy, or a home delivery (mail order) Pharmacy.

Preferred Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented and is only produced by one manufacturer. These drugs are generally covered as a Tier 2 drug.

Prescription means a written order by a practitioner licensed to prescribe.

Specialty Drugs are "bioengineered" oral or injectable medicines that target and treat complex medical conditions including: blood disorders, cancers, Infertility, hormone or enzyme deficiencies, multiple sclerosis, rheumatoid arthritis, and a growing list of obscure or "orphan" diagnoses. Specialty drugs are complex compounds and some have unique "handling" requirements. The FDA in selected situations has required dispensing from a single Pharmacy or a limited set of "approved" pharmacies. Some "specialty" drugs are oral tablets or capsules while others require injection.

Important Details About Prescription Drug Coverage
The Prescription Drug coverage under this benefit Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, the prescribing practitioner may be asked to provide more information before a decision regarding Medical Necessity can be determined. Quantity and or age limits may be set for specific Prescription Drugs or use recommendations made as part of the Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List or formulary, Therapeutic Substitution, day / supply limits, and other Utilization Reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will also be told about any details We would need to decide benefits.

Drug Utilization Review
Prescription Drug benefits include Utilization Review of Prescription Drug usage for Your health and safety. Certain Drugs may require prior authorization. Also, a Participating Pharmacist can help arrange prior authorization or dispense an Emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify Your personal practitioner licensed to prescribe and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Step Therapy
Step therapy is a process in which You may need to use one type of drug before We will cover another. We or Our Administrator will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a practitioner licensed to prescribe decides that a certain Prescription Drug is needed, the prior authorization will apply.

Tier Status
The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six (6) times per Plan Year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website www.geoblue.com or by calling the number on Your ID card.

Day Supply and Refill Limits
Certain day supply limits apply to Prescription Drugs as listed in the Schedule of Benefits. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled.

Prior Authorization for Specialty Drugs, Compound Drugs and/or Fixed Dose Combination Drugs
Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We or the Administrator will contact Your Provider to get the details they need to decide if prior authorization should be given. We or the Administrator will give the results of our decision to both You and Your Provider. The prior authorization process is also used to approve requests from Your Provider for contraceptive methods that are Medically Necessary for You based on Your medical or personal history.

Prior authorization procedures and requirements for coverage are based on clinical need and therapeutic rationale. Administration of the prior authorization process considers the desired outcome for the patient, the design of the drug benefit, the value to Us, and all statutory and regulatory requirements. The process offers the prescriber an opportunity to justify the therapeutic basis for the prescribed medication and receive information concerning the acceptance and payment of claims for a particular drug.

You may need to try a Drug other than the one originally prescribed if We determine that it should be clinically effective for You. However, if We determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, You are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for Your medical condition and You underwent a prior authorization process under a prior Plan which required You to take different Drugs, We will not require You to try a Drug other than the one You are currently taking.)

The prior authorization review process is outlined below:
1. A rejected Prescription Drug claim will initiate a request for prior authorization with a request for patient demographic and necessary clinical data of the practitioner licensed to prescribe.
2. Our Pharmacy Benefit Manager (PBM) reviews available data and determines:
    a. Information provided is sufficient to make a determination;
    b. Information provided is insufficient to make a determination and initiates fax request for necessary clinical data to prescribing practitioner within 24 hours following receipt of review request.
3. Review of historic medication claim data, standard clinical references and clinical data/information received from the practitioner licensed to prescribe.
4. Match of available data and information with labeled indication(s) for prescribed medication requiring authorization and against generally accepted clinical authorization criteria.
5. A recommendation to accept claims for payment will be made in writing and provided to Us and removal of Prior Authorization criteria in the Rx claim system will be completed.
6. A recommendation to not accept claims for payment will be made in writing and will be provided to Us the practitioner licensed to prescribe, the Prescription Drug claims processor and the Covered Person.
7. Review and recommendation to be completed within 48 hours following receipt of clinical data from practitioner.

If prior authorization is denied You have the right to file a grievance as outlined in the part WHEN YOU HAVE A COMPLAINT OR APPEAL.

For a list of Drugs that need prior authorization, please call the telephone number listed on Your ID Card or visit www.geo-blue.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which drugs are covered under the Prescription Drug coverage.

Exclusions

No payment will be made for the following expenses:

1. drugs available over the counter that do not require a Prescription by federal or state law or applicable law in the jurisdiction where the drug is purchased;
2. any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
3. a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
4. Contrary to approved medical and professional standards: Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice;
5. Compound drugs. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a compounded medicine. See the Drug Utilization Review section of this benefit;
6. Fixed Dose Combination Drugs that are not supported by medical and/or pharmaceutical literature describing a therapeutic advantage in clinical outcomes to the same or similar separately administered medicines in comparable daily doses. Case by case review is available for unique patient clinical circumstances where the only solution is to provide a Fixed Dose Combination drug. See the Drug Utilization Review section of this benefit
7. Any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents. Physician supervised or administered drugs are covered as a medical expense under the Infusion Therapy benefit.
8. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal and meets accepted clinical criteria for use;
9. prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
10. prescription and nonprescription supplies, devices, and appliances other than Related Supplies;
11. implantable contraceptive products;
12. weight management drugs;
13. diet pills or appetite suppressants (anorectics);
14. anabolic steroids;
15. growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
16. biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
17. drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
18. drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally;
19. replacement of Prescription Drugs and Related Supplies due to loss or theft;
20. drugs used to enhance athletic performance;
21. drugs which are to be taken by or administered to You while You are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
22. Prescriptions more than one year from the original date of issue;

23. any drugs that are Experimental or Investigational as described under the Medical "Exclusions" section of Your Certificate.
24. care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law
25. services rendered and separately billed by employees of Hospitals, laboratories or other institutions.
26. services for which no charge is normally made.
27. If benefits for services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
28. services that are not listed in this Certificate as being Covered.

Other limitations are shown in the Medical "Exclusions" section of Your Certificate.

Reimbursement/Filing a Claim

When You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, You pay any applicable Copayment, or Coinsurance and/or Deductible shown in the Schedule of Benefits at the time of purchase. You do not need to file a claim form.

If You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a Non-Participating Pharmacy, You pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery (mail order) Participating Pharmacy, contact customer service for assistance.

VII. Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

No coverage is available under this Certificate for the following:

1. **Convalescent and Custodial Care:** We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

2. **Conversion Therapy.** We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

3. **Cosmetic Services:** We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

4. **Dental Services:** We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate, or any attached Riders.

5. **Experimental or Investigational Treatment:** We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

6. **Felony Participation:** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

7. **Foot Care:** We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

8. **Government Facility:** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

9. **Medically Necessary:** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

10. **Medicare or Other Governmental Program:** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

11. **Military Service:** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

12. **No-Fault Automobile Insurance:** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

13. **Services Not Listed:** We do not Cover services that are not listed in this Certificate as being Covered.

14. **Services Provided by a Family Member:** We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

15. **Services Separately Billed by Hospital Employees:** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

16. **Services With No Charge:** We do not Cover services for which no charge is normally made.

17. **Vision Services:** We do not Cover the examination or fitting of eyeglasses or contact lenses, unless services are provided by attached Rider.

18. **War:** We do not Cover an illness, treatment or medical condition due to war, declared or undeclared, if Your were an active participant in the war.

19. **Workers' Compensation:** We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

VIII. General Provisions

Coordination of Benefits
This section applies if You or any one of Your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan. For claims incurred within the United States, You should file all claims under each plan. For claims incurred outside the United States, if You file claims with more than one plan, You must indicate, at the time of filing a claim under this Plan that You also have or will be filing Your claim under another plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Allowable expense
Is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the Plans involved, except where a statute requires a different definition. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

Plan
Is other group health coverage with which We will coordinate benefits. The term "plan" includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted Providers, and that limits or excludes benefits provided by Providers outside of the panel, except in the case of emergency or if referred by a Provider within the panel.

Primary Plan
Is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

- the plan has no order of benefits rules or its rules differ from those required by regulation; or
- all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a Primary Plan (for example, two plans which have no order of benefit determination rules).

Secondary Plan
A Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Allowable Expense
A necessary, reasonable and customary service or expense, including Deductibles, Coinsurance or Copayments that is covered in full or in part by any Plan covering You. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If You are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If You are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If You are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher Coinsurance percentage, a Deductible and/or a penalty) because You did not comply with Plan provisions or because You did not use a preferred Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which You are not covered under this Certificate or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed Provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules
The first of the rules listed below that applies will determine which Plan will be primary:

- If the other Plan does not have a provision similar to this one, then the other plan will be primary.

- If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other Plan, this Certificate will be primary.

- If a child is covered under the Plans of both parents and the parents are not separated or divorced, the Plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the Plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other Plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the Plans do not agree on which is primary, then the rule in the other Plan will determine which Plan is primary.

- If a child is covered by both parents' Plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
  - The Plan of the parent who has custody will be primary;
  - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's Plan, the Plan of the parent with custody will pay first, the step-parent's plan will pay second, and the Plan of the parent without custody will pay third; and
  - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's Plan will be primary if that Plan has actual knowledge of the decree.

- If the person receiving services is covered under one Plan as an active Employee or member (i.e., not laid-off or retired), or as the Spouse or child of such an active Employee, and is also covered under another Plan as a laid-off or retired Employee or as the or child of such a laid-off or retired employee, the plan that covers such person as an active employee or Spouse or child of an active Employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

- If none of the above rules determine which plan is primary, the Plan that covered the person receiving services longer will be primary.

Effects of Coordination
When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the Primary Plan and this Plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Recovery of Excess Benefits
If We made a payment as a Primary Plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the Primary Plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

Right to Receive and Release Information
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

Medicare Eligible Insured Participants
Covered Persons eligible for Medicare receive the full benefits of this Plan, except for those Covered Persons listed below:
- Covered Persons who are receiving treatment for end-stage renal disease following the first 30 months such Covered Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
- Covered Persons who are entitled to Medicare benefits as disabled persons, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more Employees (subject to COBRA legislation).
- Covered Persons who are entitled to Medicare for any other reason, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more Employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, We will determine Our payment and then subtract the amount of benefits available from Medicare. We will pay the amount that remains after subtracting Medicare's payment. Please note, We will not pay any benefit when Medicare's payment is equal to or more than the amount which We would have paid in the absence of Medicare.

For example: Assume exception 1, 2 or 3 applies to the Covered Person, and he/she is billed for $100 of Covered Expense. And assume in the absence of Medicare, We would have paid $80. If Medicare pays $50, We would subtract that amount from the $80 and pay $30. However, if in this example, Medicare's payment is $80 or more, We will not pay a benefit.

Coordination with "Always Secondary" or Non-Complying Plans
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Certificate is primary, as defined in this section, We will pay benefits first.
- If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
- If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

Assignment
You cannot assign any benefits under this Certificate to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the provision Protection from Surprise Bills for more information about surprise bills. Any assignment of benefits by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.

Changes in this Certificate
We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

Third Party Liability
This Plan does not cover:

- Expenses incurred by You or Your Dependent (individually and collectively referred to as a "Participant," in this section) for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation and Reimbursement
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your Injury, Sickness or other condition and We have provided benefits related to that Injury, Sickness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an Injury, Sickness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Sickness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

Lien of the Plan

By accepting benefits under this Plan, a Participant:

- grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Claim Process

Notice of Claim: Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.geo-blue.com. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address on Your ID card or visiting Our website at www.geo-blue.com

How To File Your Claim

There's no paperwork for U.S. Participating Provider care. Just show Your identification card and pay Your share of the cost, if any; Your Provider will submit a claim to 4 Ever Life and their Administrator for reimbursement. U.S. Non-Participating Providers and International claims can be submitted by the Provider if the Provider is able and willing to file on Your behalf. If the Provider is not submitting on Your behalf, You must send Your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim form at www.geo-blue.com or from Your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to 4 Ever Life in care of their Administrator.

Claim Reminders

- Be sure to use Your Insurance ID when Your file a claim or when You call the customer service center.
- Your Insurance ID is shown on Your identification card.
- Be sure to follow the instructions listed on the claim form carefully when submitting a claim to the Administrator.

Timely Filing of U.S. Non-Participating Providers & International Claims

4 Ever Life Insurance Company and its Administrator will consider claims for coverage under the Certificate of Coverage when proof of loss (a claim) is submitted within one year (365 days) for U.S. Non-Participating Providers and International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for U.S. Non-Participating Providers and International benefits, the claim will not be considered valid and will be denied.

Proof of Loss: Upon receipt of the notice of claim, We will provide You or to the Policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of 15 days after We receive notice of claim, You will be deemed to have complied with the proof of loss requirement upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.

Written Proof of Loss for benefits must be given within one hundred twenty (120) days after You receive the services for which payment is being requested. If it was not reasonably possible to furnish proof of loss within the 120 days, You must submit it as soon as reasonably possible.

Subject to proof of loss, all accrued benefits payable under the Plan for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

Time Payment of Claims: We shall pay the claim to You or Your Provider within 30 days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or 45 days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile, except in a case where:

- the obligation of Ours is to pay a claim submitted by a Covered Person or make a payment to a Provider is not reasonably clear; or
- when there is a reasonable basis supported by specific information that such claim or bill for health care services rendered was submitted fraudulently.

We shall pay any undisputed portion of the claim in a case where the obligation of Ours is to pay a claim or make a payment for health care services rendered is not reasonably clear due to:

- a good faith dispute regarding the eligibility of a person for coverage,
- the liability of another Insurer or corporation or organization for all or part of the claim;
- the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided.

We will notify You or Your Provider in writing within 30 calendar days of the receipt of the claim:

- that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
- to request all additional information needed to determine liability to pay the claim or make the health care payment.

Upon receipt of the requested information or an appeal of a claim or bill for health care services denied, We shall pay the claim to You or Your

Any benefits payable to the Eligible Participant and unpaid at the Eligible Participant's death will be paid to the Insured Person's estate.

Payment of Claims: We may pay all or a portion of any indemnities provided for health care services to the participating health care services Provider, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We will pay all or a portion of any indemnities provided for health care services by a nonparticipating health care services Provider directly to the Covered Person, unless the Covered Person directs otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular health care services Provider.

Payment of Benefits – To Whom Payable: Medical Benefits are assignable to the Provider. When You assign benefits to a Provider, You have assigned the entire amount of the benefits due on that claim. If the Provider is overpaid because of accepting a Covered Person's payment on the charge, it is the Provider's responsibility to reimburse the Covered Person. Because of the contracts with Providers, all claims from contracted Providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent, You or Your Dependents are responsible for reimbursing the Provider.

If any person to whom benefits are payable is a minor or in Our opinion is not able to give a valid receipt for any payment due, such payment will be made to the legal guardian. If no request for payment has been made by the legal guardian, We may, at Our option, make payment to the person or institution appearing to have assumed custody and support.

When a Covered Person passes away, We may receive notice that an executor of the estate has been established. The executor has the same rights as a Covered Person and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Us from all liability to the extent of any payment made.

Payment to a Managing Conservator: Benefits paid on behalf of a covered Dependent child may be paid to a person who is not the insured Participant if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the child.

To be entitled to receive benefits, a managing conservator of a child must submit to Us with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the insured Participant where the insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

Additional Payments for Out-of-Network Benefits: When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our allowed amount. This means that the total of Our coverage and any amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

Timely Filing of Claims: You should submit all claims within 180 days of the start of service or within thirty (30) days after the service is completed. We must receive claims:

- Within 365 days of discharge for Hospital or other medical facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies
- For Covered Persons who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

Protection from Surprise Bills

A Surprise Bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
  - A participating Physician is unavailable at the time the health care services are performed;
  - A non-participating Physician performs services without Your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A Surprise Bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a Surprise Bill, a referral to a Non-Participating Provider means:
  - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
  - The participating Physician sends a specimen taken from You in the participating Physician's office to a nonparticipating laboratory or pathologist; or
  - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any non-participating Provider charges for the Surprise Bill that exceed Your In-Network Copayment, Coinsurance or Deductible if You assign benefits to the non-participating Provider in writing. In such cases, the non-participating Provider may only bill You for Your In-Network Copayment, Coinsurance or Deductible.

The assignment of benefits form for Surprise Bills is available at www.dfs.ny.gov or You can visit Our website at www.geo-blue.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on our website and to Your Provider.

Misstatement of Age: If the age of a Covered Person has been misstated, an adjustment of premiums shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

Plan Administrator: In no event will We be the Plan Administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "Plan Administrator" refers either to the Group or to a person or entity other than Us, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health Plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Continuation (COBRA) section of this Certificate (if applicable), the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as the Participant's agent.

Waiver of Rights: Failure by Us to enforce or require compliance with any provision herein will not waive, modify or render such provision unenforceable at any other time, whether the circumstances are or are not the same.

Physical Exam and Autopsy: We will have the right and opportunity to examine the Insured making a claim as requested during the pendency of the claim, and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law If an examination or autopsy is required, You will not have to pay for it.

Required Information: The Group will furnish Us all information necessary to calculate the Premium and all other information that We may require. Failure of the Group to furnish the information will not invalidate any insurance, nor will it continue any insurance beyond the last day of coverage. We have the right to examine any records of the Group, any person, company or organization which may affect the Premiums and benefits of the Plan. Our right to examine any records that exist:

- During the time the Plan is in force; or
- Until We pay the last claim.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or Experimental or Investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

We are not responsible for any claim for damages or injuries suffered by the Covered Person while receiving care in any Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or from any Participating or Non-Participating Provider. Such facilities and Providers act as independent contractors and not as Employees, agents or representatives of Us.

We are entitled to receive from any Provider of service information about the Covered Person which is necessary to administer claims on the Covered Person's behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, the Covered Person has authorized every Provider furnishing care to disclose all facts pertaining to the Covered Person's and his/her insured Dependent's care, treatment, and physical condition, upon Our request. The Covered Person agrees to assist in obtaining this information if needed.

Right of Recovery
We have the right to recover amounts We paid that exceed the amount for which We are liable. Such amounts may be recovered from the Participant or any other payee, including a Provider. Or, such amounts may be deducted from future benefits of the Participant or any of his or her Dependents (even if the original payment was not made on that Covered Person's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a Provider that does not have a contract with Us.

In addition, if the Policy for this Plan is rescinded as described in "Intentionally False or Misleading Statements," We have the right to recover the amount of any claims We paid under this Plan and any administrative costs We incurred to pay those claims.

Hold Harmless and Assignment of Benefits for Surprise Bills
When You assign benefits for a Surprise Bill in writing to a non-participating Physician that knows You are insured under a health care plan, the non-participating Physician shall not bill Us except for any applicable copayment, Coinsurance or Deductible that would be owed if You utilized a participating Physician.

Other Provisions

Entire Contract and Changes: The entire contract between the Group and Us is as stated in the Policy and the entire contract between You and Us is as stated in the Certificate of Coverage including the endorsements, application, and the attached papers, if any. No change in the Policy or Certificate of Coverage shall be effective until approved by one of Our officers and evidences by endorsement on the Policy, or by amendment to the Policy signed by the Policyholder and Us. This approval must be noted on or attached to the Certificate of Coverage. No agent may change the Policy or waive any of its provisions.

Grace Period: There is a Grace Period of thirty-one (31) days allowed for the payment of each premium after the first premium, during which time the Policy continues in force.

Incontestability: No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

Time Limit on Certain Defenses/Misstatements on the Application: After two calendar years from the effective date of the Certificate, We will not contest the validity of the Certificate.

No statement made by You will be used to void coverage or reduce benefits unless:
- such statement is contained in a written instrument signed by You; and
- the statement is material to the risk assumed.

All statements contained in any such written instrument will be deemed representations and not warranties.

After two calendar years from the effective date of Your coverage, no statements made by You, except fraudulent misstatements, will be used to reduce or deny a claim for loss incurred or disability that starts after the two (2) year period.

Time to Sue: No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

Conformity with State Statutes: If any provision of this Plan which, on its effective date, is in conflict with the statutes of the state in which the policyholder resides, it is amended to conform to the minimum requirements of those statutes.

Provision in Event of Partial Invalidity: If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

Alternate Cost Containment Provision: If it will result in less expensive treatment, We may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by Us, the Covered Person, and the Covered Person's Physician, Provider, or other healthcare practitioner. Our offering an alternate treatment plan in a particular case in no way commits Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Covered Person.

Who May Change this Certificate: This Certificate may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

IX. When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "You", "Your" or "Covered Person" also refers to a representative or Provider designated by You to act on Your behalf, unless otherwise noted.

We want You to be completely satisfied with the care You receive. That is why We have established a process for addressing Your concerns and solving Your problems.

Start with Customer Services
We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, or contractual benefits, You can call Our toll-free number and explain Your concern to one of Our Customer Service representatives. You can also express that concern in writing. Please write to Us at the following address:

Worldwide Insurance Services, LLC
Attn: Appeals Department
933 First Avenue
King of Prussia, PA 19087

We will do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We will get back to You as soon as possible, but in any case within 30 days.

If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

Grievance Procedures

A. Grievances

Our Grievance procedure applies to any issue not relating to a Medical Necessity or Experimental or Investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance

You can contact Us by phone at the number on Your ID card or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

X. Utilization Review

A. Utilization Review

We review health services to determine whether the services are or were Medically Necessary or Experimental or Investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.geo-blue.com.

B. Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews** - If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Preauthorization Reviews -** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court

C. Concurrent Reviews

1. **Non-Urgent Concurrent Reviews -** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of Urgent Care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews -** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

4. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within 48 hours of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission

D. Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review; • The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) A Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition.

- **Out-of-Network Service Denial -** You also have the right to Appeal the denial of a Preauthorization request for an Out-of-Network health service when We determine that the Out-of-Network health service is not materially different from an available in-network health service. A denial of an Out-of-Network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an Out-of-Network health service, You or Your designee must submit:
  - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested Out-of-Network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
  - Two (2) documents from the available medical and scientific evidence that the Out-of-Network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out of- network service would likely not be substantially increased over the in-network health service.

- **Out-of-Network Referral Denial -** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an Out-of-Network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
  - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
  - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal

1. **Preauthorization Appeal -** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal -** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal -** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal -** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file an expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

I. Appeal Assistance

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

Under New York State law, Your completed request for appeal must be filed within 45 days of either the date upon which You receive written notification from Us that it has 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.

Covered Services/Exclusions - In general, the Certificate does not cover Experimental or Investigational treatments. However, the Certificate will cover an Experimental or Investigational treatment approved by an External Appeal agent in accordance with this External Appeal provision. 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 will 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 the Certificate for non-Experimental or non-Investigational treatments provided in such clinical trial.

XI. External Appeal

1. Your Right to an External Appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases); or is an Out-of-Network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

2. Your Right to Appeal a Determination that a Service is Not Medically Necessary

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "1" above.

3. Your Right to Appeal a Determination that a Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "1" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

   For 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 condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

4. Your Right to Appeal a Determination that a Service is Out-of-Network

If We have denied coverage of an Out-of-Network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "1" above, and You have requested Preauthorization for the Out-of-Network treatment. In addition, Your attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

5. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "1" above.

In addition, Your attending Physician must: certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

6. Your Right to Appeal a Formulary Exception Denial

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

7. The External Appeal Process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our 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 external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 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; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an Expedited External appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application.

Immediately after reaching a decision, the External Appeal Agent must 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 Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your External appeal and notify You or Your designee and the prescribing Health Care Professional within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your External appeal and notify You or Your designee and the prescribing Health Care Professional within 24 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an Experimental or Investigational treatment or an Out-of-Network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. 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 cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the 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 a fee of $25 for each External appeal, not to exceed $75 in a single Plan Year. The External appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

8. Your Responsibilities

It is Your responsibility to start the External appeal process. You may start the External appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for External appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

XII. Definitions

Active Service
You will be considered in Active Service:

- on any of the Employer's scheduled work days if You are performing the regular duties of Your work on that day either at the Employer's place of business or at some location to which You are required to travel for Your Employer's business.
- on a day which is not one of Your Employer's scheduled work days if You were in Active Service on the preceding scheduled work day.

Acute
Means the onset of Sickness or Injury, or a change in Your condition that would require prompt medical attention.

Allowed Amount
Allowed Amount means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted.

Ambulatory Care
Means covered services and medications that are:

- related to and necessary for the treatment or diagnosis of the Covered Person's Sickness or Injury; and
- ordered by a Physician.

Ambulatory Surgical Center
Is a facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal
A request for Us to review a Utilization Review decision or a Grievance again.

Bed and Board
The term Bed and Board includes all Charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Certificate or Certificate of Coverage
This term means this Certificate, issued by 4 Ever Life Insurance Company, including the Schedule of Benefits, and any attached riders.

Certification
The term Certification means a decision by a health care insurer that a health care service requested by a Provider or covered person has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and Medical Necessity, and the requested health care service is therefore approved.

Charges
The term Charges means the actual billed Charges; except when the Provider has contracted directly or indirectly with Us for a different amount.

Child, Children
Your Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Coinsurance
Your share of the costs of a covered service, calculated as a percent of the eligible charge for the service that You are required to pay to a Provider. The amount can vary by the type of covered service.

Complications of Pregnancy
- conditions requiring Hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
- non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

A **Continuing Hospital Confinement**
Means consecutive days of in-Hospital service received as an inpatient, or successive confinements when discharge from and readmission to the Hospital occur within a period of time not more than 90 days or three times the maximum number of days of in-Hospital coverage provided under the Certificate to a maximum of 180 days, or successive confinements due to the same or related causes unless between such confinements You have been actively at work, if an Employee, or engaged in normal activity if not an Employee, for a period of not more than 90 days. A confinement for an accidental Injury shall not be combined with another confinement for a Sickness in determining Continuing Hospital Confinement.

Cosmetic Surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

Covered Expense(s)
Covered Expenses are the expenses incurred for covered services. Covered Expenses may be limited by other specific is described in the Schedule of Benefits, and other sections of this Certificate. Covered Expenses are subject to applicable Deductible, Copayments and Coinsurance that may be imposed as specified in the Schedule of Benefits. For non-Participating Providers, only those parts of a charge that are less than or equal to the Maximum Reimbursable Charge are Covered Expenses. An expense is incurred on the date the Covered Person receives the service or supply.

Covered Person
Covered Person means an eligible Participant and any eligible Dependents enrolled in this Plan and for which the Covered Person is entitled to receive benefits.

Custodial Care
Means those services that do not require the technical skills or professional training of medical and/or Nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to You if You are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to You as an Inpatient in the health care facility involved.

Deductible
The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Dental Services described in the Certificate of Coverage.

Dependent
Dependents are:
- Your lawful Spouse or Domestic Partner;
- any child of Yours who is less than 26 years old; and
- any child, regardless of age, unmarried and who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the New York Mental Hygiene Law, or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent on You for support and maintenance. Such child will remain covered while Your insurance remains in force and Your child remains in such condition. You have 31 days from the date of Your child's attainment of the termination age to submit an application to request that the child be included in Your coverage and proof of the child's incapacity. We have the right to check whether a child is and continues to qualify.
- A child for whom You are a legal guardian if the child is chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

The term child under this Certificate means Your natural child, stepchild, legally adopted child, or proposed adoptive child without regard to financial dependence, residency with You, student status or employment.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a primary Participant will not be considered as a Dependent Spouse. A child under age 26 may be covered as either a primary Participant or as a Dependent child. You cannot be covered as a primary Participant while also covered as a Dependent of a Participant.

No one may be considered as a Dependent of more than one Participant.

Domestic Partner
A domestic Partner is a person of the same or opposite sex who is in a Domestic Partnership with an Insured Participant. Proof of the Domestic Partnership and financial interdependence must be submitted to the Insurer in the form of:
- Registration as a Domestic Partnership indicating that neither individual has been registered as a member of another Domestic Partnership within the last six months, where such registry exists, or
- For Domestic Partners residing where registration does not exist, by an alternative affidavit of Domestic Partnership.
  - The affidavit must be notarized and must contain the following:
    - The Domestic Partners are both eighteen years of age or older and are mentally competent to consent to contract.
    - The Domestic Partners are not related by blood in a manner that would bar marriage under laws of the State of New York
    - The Domestic Partners have been living together on a continuous basis prior to the date of the application; and
- Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

- Proof that the Domestic Partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
  - A joint bank account
  - A joint credit card or charge card
  - Joint obligation on a loan
  - Status as an authorized signatory on the partner's bank account, credit card or charge card
  - Joint ownership of holdings or investments
  - Joint ownership of residence
  - Joint ownership of real estate other than residence
  - Listing of both partners as tenants on the lease of the shared residence
  - Shared rental payments of residence (need not be shared 50/50)
  - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
  - A common household and shared household expenses, - e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
  - Shared household budget for purposes of receiving government benefits
  - Status of one as representative payee for the other's government benefits
  - Joint ownership of major items of personal property (e.g., appliances, furniture)
  - Joint ownership of a motor vehicle
  - Joint responsibility for child care (e.g., school documents, guardianship)
  - Shared child care expenses,- e.g., babysitting, day-care, school bills (need not be shared 50/50)
  - Execution of wills naming each other as executor and/or beneficiary
  - Designation as beneficiary under the other's life insurance policy
  - Designation as beneficiary under the other's retirement benefits account
  - Mutual grant of durable power of attorney
  - Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
  - Affidavit by creditor or other individual able to testify to partners' financial interdependence
  - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Doula
Is a certified or licensed care-giver in the country of their practice of non-medical support to women and their families during labor and childbirth, and also the postpartum period.

Durable Medical Equipment ("DME"):
Durable Medical Equipment is equipment which is:
1. Designed and intended for repeated use;
2. Primarily and customarily used to serve a medical purpose;
3. Generally not useful to a person in the absence of disease or injury; and
4. Appropriate for use in the home.

Eligible Charge
Eligible Charges is the maximum amount on which Your payment is based for covered services. See the Cost-Sharing Expenses and Eligible Charge section of this Certificate for a description of how the Eligible Charge is calculated. If your Non-Participating Provider charges more than the Eligible Charge You will have to pay the difference between the Eligible Charge and the Provider's charge, in addition to any Cost-Sharing requirements.

Emergency Accident Care
Is the initial Outpatient treatment of accidental Injuries including related diagnostic service.

Emergency Medical Care
Means services which are not subject to prior approval and are provided for the initial Outpatient treatment, including related Diagnostic Services, of an Emergency Medical Condition

Emergency Medical Care includes:
- a medical screening examination as required under 42 U.S.C. §1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 U.S.C. §1395dd to stabilize the patient.

To stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).

Emergency Medical Condition
Means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious dysfunction of any bodily organ or part of such person;
- serious disfigurement of such person; or
- a condition described in §1867€(l)(A)(i), (ii) or (iii) of the Social Security Act.

Emergency Services
Emergency Services, with respect to an Emergency Medical Condition, means:
- a medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Employee
The term Employee means a full-time employee of the Employer who is currently in Active Service who usually works at least 30 hours a week in the conduct of the Group's business. The term does not include Employees who normally work less than 30 hours a week for the Employer. An Employee does not include an employee who works on a part-time, temporary, or substitute basis.

Employer
The term Employer means a Group participating under the Policy and all affiliated Employers.

Exclusions
Exclusions are health care services We do not pay for or cover.

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.

Experimental/Investigational
Experimental/Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. We will make the final determination as to what is Experimental or Investigational. Experimental/Investigational does not include the routine medical costs associated with clinical trials.

External Appeal Agent:
An entity that has been certified by the New York State Department of Financial Services to perform External Appeals in accordance with New York law.

Facility
Means a Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Use Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:
- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and X-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Grievance
A complaint that You communicate to Us that does not involve a Utilization Review.

Group
Group refers to the Employer or party that has entered into an agreement with Us as a Policyholder.

Group Policy or Policy
Group Policy means the agreement between Us and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any employee application form of the persons covered under the Policy.

Home Country
Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an eligible Dependent who is a child is the same as that of the eligible Participant.

Home Health Agencies and Visiting Nurse Associations
An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services on a visiting basis in Your home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations, or the local/national authority if outside the United States.

Home Health Care Services
Home Health Care Services means those services and supplies from a Provider, approved by Us that is engaged in providing, either directly or through an arrangement, health care or skilled nursing services on an intermittent basis in the patient's home in accordance with an approved Home Health Care treatment Plan.

Hospice Care Program
The term Hospice Care Program means care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospice Care Services
Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital
Means a short-term, acute, general Hospital, which:
- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or Dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional Nurse (R.N.);
- if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 USCA 1395x(k));
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospital Confinement or Confined in a Hospital
A person will be considered Confined in a Hospital if he is:
- A registered bed patient in a Hospital upon the recommendation of a Physician;
- Receiving treatment for Mental Health and Substance Use Services in a Partial Hospitalization program;
- Receiving treatment for Mental Health and Substance Use Services in a Mental Health or Substance Use Residential Treatment Center.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:
- For a woman who is under 35 years of age: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury
The term Injury means an accidental bodily Injury.

Inpatient
An Inpatient Admission means a Covered Persons actual entry into a Hospital, extended care facility, or facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility, or facility Provider and for whom a Bed and Board charge is made; the Inpatient stay shall continue until such time as the Covered Person is actually discharged from the facility.

Insurer
Means 4 Ever Life Insurance Company.

International
Means any country or territory other than the United States of America, the District of Columbia, the U.S. Virgin Islands or Puerto Rico.

Maximum Reimbursable Charge
The Maximum Reimbursable Charge for covered services is determined based on the lesser of:
- the Provider's normal charge for a similar service or supply; or
- an Insurer-selected percentile of Charges made by Providers of such service or supply in the geographic area where it is received as compiled in a database selected by Us or Our designee.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Us. Additional information about how We determine the Maximum Reimbursable Charge is available upon request.

Medicaid
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity
We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to cover it.

We may base Our decision on a review of:
- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Morbid Obesity
This means:

- Your body mass index (BMI) exceeds 40; or
- Your BMI exceeds 35 and You have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Necessary Services and Supplies
The term Necessary Services and Supplies includes any Charges, except Charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any Charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any Charges, by whomever made, for the administration of anesthetics during Hospital Confinement. The term Necessary Services and Supplies will not include any Charges for special nursing fees, dental fees or medical fees.

Nurse
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Ophthalmologist
The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the Certificate of Coverage.

Optician
The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An Optician fills prescriptions for glasses and other optical aids as specified by Optometrists or Ophthalmologists. The state in which an Optician practices may or may not require licensure for rendering of these services.

Optometrist
The term Optometrist means a person practicing optometry within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the Certificate of Coverage.

Other Health Care Facility/Other Participating Health Professional
A person who is in a Provider category licensed to practice health care related services consistent with the laws in jurisdiction in which the services are performed. Such persons are considered health care Providers only to the extent services are covered by the provisions of this Plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain Health Care Facilities and other Providers of health care services and supplies, as specifically indicated in the Provider category listing below.

Covered licensed or certified categories of Providers, will include the following, provided that the services they furnish are consistent with state law, and the conditions of coverage described elsewhere in this Plan are met:

- Acupuncturists (L.Ac.), also called East Asian Medicine Practitioners (E.A.M.P.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Licensed Clinical Social Workers
- Speech-Language Pathologists

The following Health Care Facilities and other Providers of health care services and supplies will be considered health care Providers for the purposes of this Plan, as long as they are licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this Plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

Note: Outside of the United States, a Provider is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for Out-of-Network services regardless of whether the Out-of-Pocket Limit has been met.

Outpatient
Care in a Hospital that usually doesn't require an overnight stay.

Participant
An enrolled Employee of the Group. Coverage under this Plan is established in the Participant's name.

Participating Provider
The term Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Us or Our designee to provide covered services with regard to a particular Plan under which the Participant is covered.

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the Policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician.

In addition, professional services provided by one of the following types of Providers will be covered under this Plan, but only when the Provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this Plan; and providing a service for which benefits would be payable if the service were provided by a Physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.)

Note: Outside of the United States, a Physician is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Plan
Plan means the set of benefits described in the Certificate of Coverage booklet and in the amendments to this Certificate (if any). This Plan is subject to the terms and conditions of the Policy We have issued to the Group. If changes are made to the Policy or Plan, an amendment or revised Certificate will be issued to the Group for distribution to each Participant affected by the change.

Policy
Policy is the Group Policy We have issued to the Group.

Policy Year
The period of 12 consecutive months commencing with the Effective Date of the insurance contract or with an anniversary of that date.

Prescription Drug
Prescription Drug means; a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; certain drugs approved under the FDA's Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List
Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the Pharmacy & Therapeutics (P&T) Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order
Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment
The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician
Is a Physician who supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician.

Provider
Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, certified midwife, Hospital, Skilled Nursing Facility, rehabilitation Hospital, birthing facility, or home health Provider.

Psychologist
The term Psychologist means a person who is licensed or certified as a clinical Psychologist, psychologist or a licensed clinical social worker. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical Psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the Policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a Psychologist.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization
The term Review Organization refers to an affiliate of Ours or another entity to which We have delegated responsibility for performing Utilization Review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed Mental Health and Substance Use professionals, and other trained staff members who perform Utilization Review services.

Schedule of Benefits
The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits and other limits on covered services.

Sickness – For Medical Insurance
The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility
The term Skilled Nursing Facility means an institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing Skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these.

Skilled Nursing Service
Those services provided by a registered Nurse (R.N.) or licensed practical Nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

Spouse
As defined or allowed by the state of New York. includes a common law Spouse or a Domestic Partner. This term also includes a same sex partner in a marriage that was legally performed in the state of New York or any other state.

Specialist
A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. Examples include Ob/Gyn, surgeons, cardiologists, urologists, dermatologists.

Stabilize
Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Terminal Illness
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Telehealth
Telehealth means the use of electronic information and communication technologies by a Provider to deliver health care services to a Covered Person while the Covered Person is located at a site that is different from the site where the Provider is located.

Totally Disabled
With respect to an Eligible Person, an inability by reason of Sickness, Injury or physical condition from engaging in any work or other gainful activity. Total disability for a minor means the inability by reason of Sickness, Injury or physical condition to engage in substantially all of the normal activities of a person of the same age and sex who is in good health.

Urgent Care
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Us, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where You ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

U.S.
Means the United States of America, including the District of Columbia, the U.S. Virgin Islands and Puerto Rico.

We, Us and **Our**
Means 4 Ever Life Insurance Company.

You, Your
Means an eligible Participant or eligible Dependent.

SECTION XIII. IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Important Telephone Numbers and Addresses

CLAIMS
Worldwide Insurance Services, LLC
Claims Department
933 First Avenue
King of Prussia, PA 19406
(Submit Claim forms to this address.)

claims@geo-blue.com
(Submit electronic claim forms to this e-mail address)

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
Call the number on Your ID card

Assignment of Benefits Form
Worldwide Insurance Services, LLC
Claims Department
933 First Avenue
King of Prussia, PA 19406
(Submit assignment of benefits forms for Surprise Bills to this address.)

MEMBER SERVICES
Call the number on Your ID card
(Member Services Representatives are available 24 hours a day.)

PREAUTHORIZATION
Call the number on Your ID card

OUR WEBSITE
www.geo-blue.com

4 Ever Life Insurance Company

2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181
(888) 923-4227

Administrative Office:
Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

4 EVER LIFE INSURANCE COMPANY
2 Mid-America Plaza, Ste. 200
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Medical Assistance Rider

We will pay for Covered Services up to the maximum stated below per Policy Year, unless otherwise stated, for the medical assistance services listed below. The Deductible is not applicable.

EMERGENCY MEDICAL EVACUATION	Maximum Benefit up to $250,000
REPATRIATION OF MORTAL REMAINS	Maximum Benefit up to $25,000
EMERGENCY FAMILY TRAVEL ARRANGEMENTS	Maximum Benefit up to $2,500

Emergency Medical Evacuation Benefit
If You suffer a life-threatening/limb-threatening medical condition, and We, and/or Our designee, determines that adequate medical facilities are not available locally, We, or Our designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Us at the phone number indicated on Your identification card to begin this process.

In making a determination, We, and/or Our designee, will consider the nature of the emergency, Your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of Your evacuation to be considered an emergency and requiring emergency evacuation.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

As part of a medical evacuation, the Administrator shall also make all necessary arrangements for ground transportation to and from the Hospital, as well as pre-admission arrangements, where possible, at the receiving Hospital.

Repatriation
Following any covered emergency evacuation, We will pay for one of the following:
1. If it is deemed Medically Necessary and appropriate by Our or Our designee's medical director, You will be transferred to Your permanent residence via a one-way economy airfare or;
2. You will be transferred back to Your original work location or the location from which You were evacuated via a one-way economy airfare.

If Your transportation needs to be medically supervised a qualified medical attendant will escort You. Additionally, if We and/or Our designee determine a mode of transport other than economy class seating on a commercial aircraft is required, We or Our designee will arrange accordingly and such will be covered by Us.

Return of Dependent Children
If You have minor children who are left unattended as a result of Your Injury, Sickness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to Your Home Country or country of assignment.

Repatriation of Mortal Remains Benefit
If You die while covered under this Policy, We will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to Your Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by Us or Our designee.

No benefit is payable if the death occurs after the termination date of the Policy. We will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

The benefit for all necessary Repatriation or Mortal Remains services are listed above.

Emergency Family Travel Arrangements Benefit
If We determine that You are expected to require hospitalization in excess of 7 days at the location to which You are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by You. If Your Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

If We determine that You are expected to require hospitalization due to an Injury or Sickness for more than 7 days or are in critical condition while traveling outside of Your Home Country, We will pay up to the maximum benefit as listed above for the cost of one economy round trip air fare ticket to, and the hotel accommodations in, the location of Your Hospital Confinement for one person designated by You. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

The benefit for all necessary Emergency Family Travel Arrangements is listed above.

General Limitations/Exclusions for Evacuation Benefits
No payment will be made for charges for:
1. Services rendered without the authorization or intervention of Us or Our designee;
2. Non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to You;
3. A condition which would allow for treatment at a future date convenient to You and which does not require emergency evacuation or repatriation;
4. Medical care or services scheduled for You or Your Provider's convenience which are not considered an emergency;
5. Expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
6. Services provided for which no charge is normally made;
7. Expenses incurred while serving in the armed forces of another country;
8. Transportation for Your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
9. Service provided other than those indicated in this rider;
10. For claim payments that are illegal under applicable law.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company


PRESIDENT


SECRETARY

4 EVER LIFE INSURANCE COMPANY
2 Mid-America Plaza, Ste. 200
Oakbrook Terrace, Illinois 60181

Administrative Office:
GeoBlue
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

Accidental Death & Dismemberment Rider

We will pay the benefit stated below if a Covered Person sustains an Injury resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Accidental Death & Dismemberment Benefit

Maximum Benefit	Principal Sum up to: $50,000 per Covered Person

Loss	**Benefit**
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the total and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same accident, We will pay 100% of the Principal Sum. In no event will We pay more than the Principal Sum for loss to the Covered Person due to any one accident.

Benefits payable are subject to the Limitations and Expenses not Covered as listed in this Rider.

Special Limitations/Expenses Not Covered
Benefits will not be provided for the following:

1. For loss of life or dismemberment due to a Sickness, disease or infection.
2. For any loss of life or dismemberment before the effective date of coverage.
3. For any loss of life or dismemberment after coverage ends.
4. For loss of life or dismemberment for or arising from an Injury in the Covered Person's Home Country;
5. For loss of life or dismemberment resulting directly or indirectly from the discharge, explosion, or use of any device, weapon, material employing or involving fission, nuclear fusion, or radioactive force, or chemical, biological radiological or similar agents, whether in time of peace or war, and regardless of any other causes or events contribution concurrently or in any other sequence there to.
6. For loss of life or dismemberment caused by or contributed by (a) An act of war; (b) A Covered Person participating in the military service of any country; (c) A Covered Person participating in an insurrection, rebellion, or riot; (d) Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life Insurance Company


PRESIDENT


SECRETARY