MOLINA HEALTHCARE

Your Extended Family.

Essential Plan I PLUS Subscriber Agreement

July 1, 2020

5232 Witz Drive | North Syracuse, NY 13212-6501

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Non-Discrimination Notification
Molina Healthcare of New York, Inc.

Molina Healthcare of New York, Inc. (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services at 1-800-223-7242 or TTY: 711.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (310) 507-6186.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-223-7242 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-223-7242 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-223-7242（TTY：711）。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-223-7242 (телетайп: 711).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-223-7242 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-223-7242 (TTY: 711) 번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-223-7242 (TTY: 711).
Yiddish	אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-223-7242 (TTY: 711).
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-223-7242 (TTY: 711)।
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-223-7242 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-223-7242 (رقم هاتف الصم والبكم: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-223-7242 (ATS: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-223-7242 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-223-7242 (TTY: 711).
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-223-7242 (TTY: 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-223-7242 (TTY: 711).
Nepali	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-223-7242 (टिटिवाइ: 711) ।

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Contract.

Acute: The onset of disease or injury, or a change in the Subscriber's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost–Sharing Expenses and Allowed Amount section of this Contract for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: 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.

Balance Billing: When a Non–Participating Provider bills You for the difference between the Non–Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Contract: This Contract issued by Molina Healthcare, including the Schedule of Benefits and any attached riders.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost–Sharing: Amounts You must pay for Covered Services, expressed as Copayments and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Contract.

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

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;

- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: 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 such Emergency 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 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).

Exclusions: Health care services that We do not pay for or Cover.

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: 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 Abuse 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.

Federal Poverty Level (FPL): A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain program and benefits, including the Essential Plan, and are updated on an annual basis.

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

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech–language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Contract.

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Home Health Agency: 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.

Hospice Care: 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: 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 42 U.S.C. Section 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.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

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

Lawfully Present Immigrant: The term "lawfully present" includes immigrants who have:
- "Qualified non–citizen" immigration status without a waiting period
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non–immigration visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals). To see a full list of eligible immigration statuses, please visit the web site at www.healthcare.gov/immigrants/immigration-status/ or call the NY State of Health at 1–855–355–5777.

Medically Necessary: See the How Your Coverage Works section of this Contract for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and Cost–Sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan.

Non–Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. The services of Non–Participating Providers are Covered only for Emergency Services or when authorized by Us.

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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. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.MolinaHealthcare.com or upon Your request to Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12–month period beginning on the effective date of the Contract or any anniversary date thereafter, during which the Contract is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Contract.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self–administration or administration by a non–skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine or family practice Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Contract that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for the Subscriber.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Contract that describes the Copayments, Coinsurance, Out–of–Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Allegany, Broome, Cattaraugus, Chautauqua, Cortland, Chenango, Erie, Genesee, Livingston, Monroe, Onondaga, Ontario, Orleans, Seneca, Tioga, Tompkins, Wayne and Wyoming counties.

Skilled Nursing Facility: 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 authorities.

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.

Subscriber: The person to whom this Contract is issued. Whenever a Subscriber is required to provide a notice pursuant to a Grievance or Emergency Department admission or visit, "Subscriber" also means the Subscriber's designee.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Molina Healthcare and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Subscriber.

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SECTION II

How Your Coverage Works

A. Your Coverage Under this Contract.
You have purchased or been enrolled in an Essential Plan. We will provide the benefits described in this Contract to You. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.
You will receive Covered Services under the terms and conditions of this Contract only when the Covered Service is:
- Medically Necessary;
- Provided by a Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre–Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

C. Participating Providers.
To find out if a Provider is a Participating Provider:
- Check Our Provider directory, available at Your request;
- Call (800) 223–7242 (TTY: 711) or
- Visit Our website at www.MolinaHealthcare.com.

D. The Role of Primary Care Physicians.
This Contract has a gatekeeper, usually known as a Primary Care Physician ("PCP"). This Contract requires that You select a PCP. Although You are encouraged to receive care from Your PCP, You do not need a written Referral from a PCP before receiving Specialist care from a Participating Provider. You may select any participating PCP who is available from the list of PCPs in the Essential Plan Molina Network. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Contract for more information about designating a Specialist.

For purposes of Cost–Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost–Sharing in the Schedule of Benefits section of this Contract when the services provided are related to specialty care.

E. Out–of–Network Services.
The services of Non–Participating Providers are not Covered except Emergency Services or unless specifically Covered in this Contract.

F. Services Not Requiring a Referral from Your PCP.
Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:
- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such

annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre–Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening; and
- All other services from Participating Providers.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Contract for the services that require a Referral.

G. Access to Providers and Changing Providers.
Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is accepting new patients.

You may change Your PCP within 30 days of you last appointment with your PCP by calling (800) 223–7242 (TTY: 711) or though the member portal at www.MyMolina.com. You may change Your Specialist within 30 days of Your last appointment with your specialist by talking to your PCP. Your PCP can help you if you need a different Specialist. You can also call (800) 223–7242 (TTY: 711) or visit the member portal at www.MyMolina.com.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non–Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non–Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in–network Cost–Sharing.

H. Services Subject to Preauthorization.
Our Preauthorization is required before You receive certain Covered Services. Your PCP is responsible for requesting Preauthorization for in–network services listed in the Schedule of Benefits section of this Contract.

I. Notification Procedure.
If You seek coverage for services that require notification, Your Provider must call Us at (800) 223–7242 (TTY: 711).
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.

You must contact Us to provide notification as follows:
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

J. Medical Management.
The benefits available to You under this Contract are subject to pre–service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost–

effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.
We Cover benefits described in this Contract 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.

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 Contract for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Protection from Surprise Bills.

1. 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 non–participating 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 Contract.

You will be held harmless for any Non–Participating Provider charges for the surprise bill that exceed Your In–Network Copayment, Deductible or Coinsurance 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, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.MolinaHealthcare.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 Your ID card and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

M. Delivery of Covered Services Using Telehealth.
If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Contract that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

N. Case Management.
Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health–related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community–based programs and services to meet Your needs, which may include giving You information about external agencies and community–based programs and services.

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O. Important Telephone Numbers and Addresses.

- CLAIMS
  Molina Healthcare of New York, Inc.
  P.O. Box 22615
  Long Beach, CA 90801
  (Submit claim forms to this address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  (800) 223–7242 (TTY: 711)

- Assignment of Benefits Form
  Refer to the address on Your ID card
  (Submit assignment of benefits forms for surprise bills to this address.)

- MEMBER SERVICES
  (800) 223–7242 (TTY: 711); Call the number on Your ID card
  (Member Services Representatives are available Monday – Friday, 8:00 a.m. – 6:00 p.m.)

- PREAUTHORIZATION
  (800) 223–7242 (TTY: 711)

- BEHAVIORAL HEALTH SERVICES
  (800) 223–7242 (TTY: 711)

- OUR WEBSITE
  www.MolinaHealthcare.com

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SECTION III

Access to Care and Transitional Care

A. Authorization to a Non–Participating Provider.
If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non–Participating Provider. Your Participating Provider must request prior approval of the authorization to a specific Non–Participating Provider. Approvals of authorizations to Non–Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non–Participating Provider You requested. If We approve the authorization, all services performed by the Non–Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non–Participating Provider and You. Covered Services rendered by the Non–Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in–network Cost–Sharing. In the event an authorization is not approved, any services rendered by a Non–Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.
If You have a life–threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non–participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non–participating Specialist, Covered Services rendered by the non–participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in–network Cost–Sharing.

C. Standing Authorization to a Participating Specialist.
If You need ongoing specialty care, You may receive a "standing authorization" to a Specialist who is a Participating Provider. This means that You will not need a new authorization from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing authorization. Any authorization will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing authorization to a non–participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing authorization to a non–participating Specialist, Covered Services rendered by the non–participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in–network Cost–Sharing.

D. Specialty Care Center.
If You have a life–threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request an authorization to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such an authorization. Any authorization will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve an authorization to a non–

participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve an authorization to a non–participating specialty care center, Covered Services rendered by the non–participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in–network Cost–Sharing.

E. When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in–network Cost–Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.
If You are in an ongoing course of treatment with a Non–Participating Provider when Your coverage under this Contract becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non–Participating Provider for up to 60 days from the effective date of Your coverage under this Contract. This course of treatment must be for a life–threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non–Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Contract becomes effective. You may continue care through delivery and any post–partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non–Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in–network Cost–Sharing.

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SECTION IV

Cost–Sharing Expenses and Allowed Amount

A. Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Contract for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

B. Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as shown in the Schedule of Benefits section of this Contract.

C. Out–of–Pocket Limit.
When You have met Your Out–of–Pocket Limit in payment of Copayments and Coinsurance for a Plan Year in the Schedule of Benefits section of this Contract, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year.

The Preauthorization penalty described in the How Your Coverage Works section of this Contract does not apply toward Your Out–of–Pocket Limit. The Out–of–Pocket Limit runs on a Plan Year basis

D. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Contract, before any applicable Copayment or Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount will be the amount We have negotiated with the Participating Provider.

See the Emergency Services and Urgent Care Section of this Contract for the Allowed Amount for Emergency Services rendered by Non–Participating Providers. See the Ambulance and Pre–Hospital Emergency Medical Services section of this Contract for the Allowed Amount for Pre–Hospital Emergency Medical Services rendered by Non–Participating Providers.

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SECTION V

Who is Covered

A. Who is Covered Under this Contract.
You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. You must have a household income above 138% through 200% of the Federal Poverty Level. If You are enrolled in Medicare or Medicaid, You are not eligible to purchase this Contract. Also, if Your income is above 138% of the Federal Poverty Level, You are not eligible to purchase this Contract if You are under 19 years old, greater than 64 years old, or are pregnant.

You must report changes that could affect your eligibility throughout the year, including whether You become pregnant. If you become pregnant while enrolled in this product, You become eligible to obtain Medicaid. We strongly encourage pregnant women to enroll in Medicaid to ensure that newborns have continuous coverage from their birth, as newborns are not covered under the Essential Plan. If You transition to Medicaid, Your newborn will automatically be enrolled in Medicaid from their birth without a gap in coverage.

B. Types of Coverage.
The only type of coverage offered under the Essential Plan is Individual coverage, which means only You are covered. If additional members of Your family are also covered under the Essential Plan, they will receive a separate Contract and, if applicable, they will have a separate premium.

C. Enrollment.
You can enroll in this Contract during any time of the year. If the NYSOH receives Your selection on or before the 15th of any month, Your coverage will begin on the 1st of the following month, as long as any applicable Premium payment is received by then. If the NYSOH receives Your selection on or after the 16th of the month, Your coverage will begin on the 1st of the next successive month. For example, if You make a selection on January 16, Your coverage will begin on March 1. Your first Premium payment must be received by no later than ten (10) days into the first month of coverage or ten (10) days from the date of receipt of invoice, whichever is later. If the NYSOH receives Your selection on or before December 15, 2016, Your coverage will begin on January 1, 2017, as long as the applicable Premium payment is received no later than January 10, 2017, or 10 days from the date of receipt of invoice, whichever is later.

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SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost–Sharing (Copayments, or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost–Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost–Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at (800) 223–7242 (TTY: 711) or visit Our website at www.MolinaHealthcare.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. 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 at www.MolinaHealthcare.com, or will be mailed to You upon request.

You are eligible for a physical examination once every calendar 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, 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.

B. Adult Immunizations.
We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments or Coinsurance when provided in accordance with the recommendations of ACIP.

C. Well–Woman Examinations.
We Cover well–woman examinations which consist of a routine gynecological examination, breast examination and annual cervical cancer screening tests, including laboratory and diagnostic services in connection with evaluating the screening for cervical cancer. 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.MolinaHealthcare.com, or will be mailed to You upon request. This benefit is not subject to Copayments 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.

D. 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 Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member 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 Member'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 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.

E. Family Planning and Reproductive Health Services.
We Cover family planning services which consist of FDA–approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Contract, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments 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.

We also Cover vasectomies subject to Copayments or Coinsurance.

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

F. Bone Mineral Density Measurements or Testing.
We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Contract. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:
- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- 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 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.

G. Screening for Prostate Cancer.
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.

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SECTION VII

Ambulance and Pre–Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre–Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. **Pre–Hospital Emergency Medical Services.**
   We Cover Pre–Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

   "Pre–Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non–airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such 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 functions;
   - 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 applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non–Participating Provider the usual and customary charge for Pre–Hospital Emergency Services, which shall not be excessive or unreasonable.

2. **Emergency Ambulance Transportation.**
   In addition to Pre-Hospital Emergency Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non–Emergency Ambulance Transportation.
We Cover non–emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:
- From a non–participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost–effective Acute care Facility; or
- From an Acute care Facility to a sub–Acute setting.

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C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non–ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non–emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick–up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

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SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.
We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings;
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**. If You are uncertain whether a Hospital emergency department is the most appropriate place to receive care, You can call Us before You seek treatment. Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.

We do not Cover follow–up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow–up care.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Contract within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services at a non–participating Hospital at the in–network Cost–Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital, unless We authorize continued treatment at the non–participating Hospital. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and work with You to arrange the transfer. Any inpatient Hospital services received from a non–participating Hospital after We have notified You and offered assistance in arranging and/or arranged for a transfer to a participating Hospital will not be Covered.

3. **Payments Relating to Emergency Services Rendered.** The amount We pay a Non–Participating Provider for Emergency Services will be the amount We have negotiated with the Non–Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non–Participating Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non–Participating Provider (i.e., the amount We would pay in the absence of any Cost–Sharing that would otherwise apply for services of Non–Participating Providers).

   You are responsible for any Copayment or Coinsurance. You will be held harmless for any Non–Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in Our Service Area**.

1. **In–Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out–of–Network.** We Cover Urgent Care from a non–participating Urgent Care Center or Physician outside Our Service Area. However, You must obtain Preauthorization from Us. Please contact Us at (800) 223–7242 (TTY: 711) and You will be provided with instructions. We are available 24 hours a day, seven (7) days a week to help You in urgent medical situations.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

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SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

B. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

C. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

D. Chemotherapy.
We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy may be administered by injection or infusion. Orally–administered anti–cancer drugs are Covered under the Prescription Drug Coverage section of this Contract.

E. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician 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 Contract.

F. Clinical Trials.
We Cover the routine patient 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 Contract.

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 Contract 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.

G. Dialysis.
We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non–Participating Provider subject to all 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 Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non–Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30–day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than 10 dialysis treatments by a Non–Participating Provider per calendar year.
- Benefits for services of a Non–Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost–Sharing that applies to dialysis treatments by a Participating Provider. However, You are also 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.

H. 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 for up to 60 visits per condition, per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

I. Home Health Care.
We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:
- Part–time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part–time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

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J. Infertility Treatment.
We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Subscriber 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, Subscribers 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.

2. **Comprehensive Infertility Services.** 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.

3. **Exclusions and Limitations.** We do not Cover:
   - In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs for an ovum donor or donor sperm;
   - Sperm storage costs;
   - Cryopreservation and storage of embryos;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and relating to surrogate motherhood;

- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

K. Infusion Therapy.
We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self–injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Interruption of Pregnancy.
We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions for one (1) procedure per Member, per Plan Year.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.
We Cover x–ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x–rays, x–ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.
We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Contract for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of purchase of one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider.

O. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

P. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Contract that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation. Unless You are receiving preadmission testing, Hospitals are not Participating Providers for outpatient laboratory procedures and tests.

Q. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities 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.

R. Prescription Drugs for Use in the Office and Outpatient Facilities.
We Cover medications and injectables (excluding self–injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Contract.

S. Rehabilitation Services.
We Cover Rehabilitation 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 for up to 60 visits per condition per plan year. The visit limit applies to all therapies combined. For the purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.

We Cover speech and physical therapy only when:
- Such therapy is related to the treatment or diagnosis of Your physical illness or injury;
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

T. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, 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. You may obtain a second opinion from a Non–Participating Provider on an in–network basis when Your attending Physician provides a written authorization request to a non–participating Specialist.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

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U. 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 post–operative 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.

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

If Covered multiple surgical procedures are performed during the same operative session through the same or 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.

V. 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.

W. 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.

X. Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:
- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Y. Transplants.
We Cover only those transplants determined to be non–experimental and non–investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott–Aldrich Syndrome.

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All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Subscriber–recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is covered by Us. We do not Cover the medical expenses of a non–covered individual acting as a donor for You if the non–covered individual's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

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SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.
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. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

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. "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. 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 Contract. 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 Contract.

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 Contract.

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

   Nothing in this Contract 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.

B. 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.

Diabetic equipment and supplies are limited to a 30–day supply up to a maximum of a 90–day supply when purchased at a pharmacy.

2. **Self–Management Education.**
Diabetes self–management education is 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 or otherwise Medically Necessary.

   Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:
   - Diabetic glucose meters and test strips;
   - Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
   - Insulin;
   - Injectable anti–diabetic agents; and
   - Oral anti–diabetic agents.

   For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Contract.

C. Durable Medical Equipment and Braces.
We Cover the rental or purchase of durable medical equipment and braces.

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

   Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over–the–counter durable medical equipment.

   We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.**
   We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.

1. **External Hearing Aids.**
   We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying

devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

2. **Cochlear Implants.**
   We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:
   - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Contract. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.
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; or homemaker, caretaker, or respite care.

F. Medical Supplies.
We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Contract. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Contract. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over–the–counter medical supplies. See the Diabetic Equipment, Supplies, and Self–Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. **External Prosthetic Devices.**
   We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

   We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered under this section of the Contract and are only Covered under the Vision Care section of this Contract.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device, per limb, per lifetime. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. **Internal Prosthetic Devices.**
We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

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SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.
We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, 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 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.

The Cost–Sharing requirements in the Schedule of Benefits section of this Contract apply to a continuous Hospital confinement, which is consecutive days of in–Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital for the same or related causes occur within a period of not more than 90 days.

B. Observation Services.
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Contract.

D. Inpatient Stay for Maternity Care.
We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in

breast or bottle–feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48–hour or 96–hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Contract and shall not be subject to any Cost–Sharing amounts in the Schedule of Benefits section of this Contract that apply to home care benefits. We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Subscribers 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.

F. Autologous Blood Banking Services.
We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.
We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

H. Rehabilitation Services.
We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit applies to all therapies combined.

We Cover speech and physical therapy only when:
1. Such therapy is related to the treatment or diagnosis of Your physical illness or injury;
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:
1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi–private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Contract). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days per Plan Year for non–custodial care.

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J. 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 Contract 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:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Limitations/Terms of Coverage.
1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi–private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.

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SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Contract 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 Addiction Equity Act of 2008.

A. Mental Health Care Services.

1. **Inpatient Services.** We Cover inpatient 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 Contract. 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 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 mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; a psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof.

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, counseling, and medication–assisted 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 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.

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SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.
We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self–injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre–natal vitamins, vitamins with fluoride, and single entity vitamins.
- Nutritional formulas for the treatment of phenylketonuria, branched–chain ketonuria, galactosemia and homocystinuria.
- Prescription or non–prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed 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; gastroesophageal 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.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Contract.
- Off–label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) 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.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs including over–the–counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.MolinaHealthcare.com. You may inquire if a specific drug is Covered under this Contract by contacting Us at (800) 223–7242 (TTY: 711).

B. Refills.
We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order or Designated pharmacy as ordered by an authorized Provider and only after 85% of the original retail or 65% of the original mail order Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost–Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Contract.

C. Benefit and Payment Information.

1. **Cost–Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Contract when Covered Prescription Drugs are obtained from a retail or mail order or Designated pharmacy. You have a three (3) tier plan design, which means that Your out–of–pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out–of–pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

   You are responsible for paying the full cost (the amount the pharmacy charges You) for any non–Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost–Sharing;
   - The Prescription Drug Cost for that Prescription Drug; or
     (Your Cost–Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non–Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required Cost–Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at (800) 223–7242 (TTY: 711) or visit our website at www.MolinaHealthcare.com to request approval.

3. **Non–Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non–Participating retail or mail order Pharmacy other than as described above.

4. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

   If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have coverage for that Prescription Drug.

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

- Acromegaly
- Allergen Immunotherapy
- Alpha – 1 Antitrypsin Deficiency
- Anemia
- Asthma
- Atopic Dermatitis
- Bone Disorders – Other
- Botulinum Toxins
- Cardiac Disorders
- Certain Composite Skin Grafts
- Certain Metabolic Agents
- Certain Posterior Pituitary Hormones
- Coagulation Disorders
- Contraceptives
- Cryopyrin – Associated Periodic Syndrome
- Cryopyrin – Associated Periodic Syndromes
- Cushing's Syndrome
- Cystic Fibrosis
- Dupuytren's Contracture
- Egrifta
- Electrolyte Disorders
- Fuzeon
- Gastrointestinal Disorders – Other
- GNRH
- Gout
- Growth Hormone And Related Disorders
- Hematopoietics
- Hemophilia
- Hepatitis C
- Hereditary Angioedema
- Hereditary Orotic Aciduria
- Hormonal Therapies
- Immune (Idiopathic) Thrombocytopenic P
- Immune (Idiopathic) Thrombocytopenic Purpura
- Immune Deficiencies And Related Disord
- Immune Deficiencies And Related Disorders
- Infectious Disease
- Infertility
- Inflammatory Bowel Disease
- Iron Overload
- Lipid Disorders
- Lipid Disorders – Pcsk9 Inhibitors
- Lipodystrophy
- LMWH
- Lysosomal Storage Disorder
- Migraine

- Miscellaneous
- Movement Disorders
- Multiple Sclerosis
- Muscular Dystrophy
- Neuromuscular
- Neutropenia
- Oncology
- Osteoarthritis
- Osteoporosis
- Pain Management
- Paroxysmal Nocturnal Hemoglobinuria
- Phenylketonuria
- Pre – Term Birth
- Psoriasis
- Pulmonary Arterial Hypertension
- Pulmonary Disorders – Other
- Renal Disease
- Respiratory Syncytial Virus
- Retinal Disorders
- Rheumatoid Arthritis
- Seizure Disorders
- Sleep Disorder
- Systemic Lupus Erythematosus
- Urea Cycle Disorders
- Venous Insufficiency
- Vivitrol

5. **Designated Retail Pharmacy for Maintenance Drugs.** You may also fill Your Prescription Order for Maintenance Drugs for up to a 90–day supply at a Designated retail Pharmacy after an initial 30–day supply. See the Supply Limits paragraph below for information regarding supply limits for contraceptive drugs and devices. You are responsible for paying the lower of:
   - The applicable Cost–Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.
     (Your Cost–Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90–day supply, with Refills when appropriate (not a 30–day supply with three (3) Refills).

   Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:
   - Asthma;
   - Blood pressure;
   - Contraceptives;
   - Diabetes;
   - High cholesterol.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

The Maintenance Drug list is updated periodically. Visit Our website at www.MolinaHealthcare.com or call (800) 223–7242 (TTY: 711) to find out if a particular Prescription Drug is on the maintenance list.

6. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order supplier after an initial 30–day supply, with the exception of contraceptive drugs or devices which are available for an initial three (3) month supply. We will only Cover drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports through a mail order pharmacy. Other drugs may also be purchased at a mail order pharmacy. You are responsible for paying the lower of:
   - The applicable Cost–Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.
     (Your Cost–Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90–day supply, with Refills when appropriate (not a 30–day supply with three (3) Refills). You will be charged the mail order Cost–Sharing for any Prescription Orders or Refills sent to the mail order supplier regardless of the number of days supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

   For Prescription Drugs that have a restricted distribution by the FDA or require special handling, provider coordination or patient supports, You may obtain Your first two (2) Prescription Orders at a retail Participating Pharmacy. After Your first two (2) Prescription Orders, You must obtain these Prescription Drugs from Our mail order pharmacy or You must opt out of obtaining Your Prescription Drugs from Our mail order pharmacy. You may opt out by visiting Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711). You must opt out on an annual basis.

   We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

7. **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 (other than a Brand–Name Drug that becomes available as a Generic Drug as described below) 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 at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

8. **When a Brand–Name Drug Becomes Available as a Generic Drug.** When a Brand–Name Drug becomes available as a Generic Drug, the tier placement of the Brand–Name Prescription Drug may change. If this happens, the Brand–Name Drug will be removed from the Formulary and You no longer have benefits for that particular Brand–Name Drug. Please note, if You are taking a Brand–Name Drug that is being excluded due to a Generic Drug becoming available, You will receive advance written notice of the Brand–Name Drug exclusion. You may request a Formulary exception as outlined below and in the External Appeal section of this Contract.

9. **Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically–appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non–Formulary drug, or would have adverse effects. If coverage is denied under Our standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Contract. Visit Our website at www.MolinaHealthcare.com or call (800) 223–7242 (TTY: 711) to find out more about this process.

   Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 72 hours after Our receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

   Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non–formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional no later than 24 hours after Our receipt of Your request. If We approve the request, 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.

10. **Supply Limits.** We will pay for no more than a 30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost–Sharing amount for up to a 30–day supply. However, for maintenance drugs We will pay for up to a 90–day supply of a drug purchased at a retail pharmacy. You are responsible for 2.5 times the cost sharing amount for a 90–day supply at a retail pharmacy.

    You may have an initial three (3) month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices 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 Pharmacy.

    Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90–day supply. You are responsible for one (1) Cost–Sharing amount for a 30–day supply up to a maximum of two (2); two and a half 2.5 Cost–Sharing amounts for a 90–day supply.

    Specialty Prescription Drugs may be limited to a 30–day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711) for more information on supply limits for specialty Prescription Drugs.

    Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month’s supply. You can determine whether a Prescription Drug has been

assigned a maximum quantity level for dispensing by accessing Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711). If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Contract.

11. **Emergency Supply of Prescription Drugs for Substance Use Disorder Treatment.** If You have an Emergency 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 prorated. If You receive an additional supply of the Prescription Drug within the 30–day period in which You received the emergency supply, Your Copayment for the remainder of the 30–day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30–day supply.

    In this paragraph, "Emergency 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.

12. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be prorated. If You receive an additional supply of the Prescription Drug within the 30–day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30–day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30–day supply.

13. **Cost–Sharing for Orally–Administered Anti–Cancer Drugs.** Your Cost–Sharing for orally–administered anti–cancer drugs is at least as favorable to You the Cost–Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Contract.

14. **Half Tablet Program.** Certain Prescription Drugs may be designated as eligible for Our voluntary half tablet program. This program provides the opportunity to reduce Your Prescription Drug out–of–pocket expenses by up to 50% by using higher strength tablets and splitting them in half. If You are taking an eligible Prescription Drug, and You would like to participate in this program, please call Your Physician to see if the half tablet program is appropriate for Your condition. If Your Physician agrees, he or she must write a new prescription for Your medication to enable Your participation.

    You can determine whether a Prescription Drug is eligible for the voluntary half tablet program by accessing Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

15. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get a 15–day

supply (or appropriate amount of medication needed for an average infertility treatment cycle) of Your Prescription Order for certain drugs filled at a Designated, retail, or mail order pharmacy instead of the full Prescription Order. You initially pay half the 30–day Cost–Sharing .The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti–infectives, Infertility, Iron Toxicity, Certain Respiratory Disorders, Mental/ Neurologic Disorders, Multiple Sclerosis, and Oncology. With the exception of Infertility drugs, this program applies for the first 60 days when You start a new Prescription Drug. For Infertility drugs, the program applies to Your infertility treatment cycle. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

D. Medical Management.

This Contract includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.MolinaHealthcare.com or call (800) 223–7242 (TTY: 711). The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Contract. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence–based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost–effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Contract.

3. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at www.MolinaHealthcare.com or call (800) 223–7242 (TTY: 711).

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) main active ingredient for the FDA approved indication that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $150 require Your Provider to obtain Preauthorization. Compounded Prescription Drugs are on tier 3.

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

5. Injectable drugs (other than self–administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Contract.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Contract.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over–the–counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Contract. We do not Cover Prescription Drugs that have over–the–counter non–prescription equivalents, except if specifically designated as Covered in the drug Formulary, or as otherwise stated in this Contract. Non–prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Contract.

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

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F. General Conditions.

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

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Contract).

1. **Brand–Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand–Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand–Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Contract. This list is subject to Our periodic review and modification (generally quarterly, but no more than six (6) times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website at www.MolinaHealthcare.com or by calling (800) 223–7242 (TTY: 711).

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand–Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long–term and which usually requires daily use of Prescription Drugs.

6. **Non–Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Subscribers. We will not make any payment for prescriptions or Refills filled at a Non–Participating Pharmacy other than as described above.

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail–order pharmacy.

8. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non–skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Contract includes coverage at Non–Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non–Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

10. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

11. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826–a of the New York Education Law.

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SECTION XIV

Wellness Benefits

A. Exercise Facility Reimbursement.
We will partially reimburse You for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness. We will also reimburse fees paid for exercise classes (e.g., yoga, pilates, spinning).

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:
- Be an active member of the exercise facility or attend classes at the exercise facility; and
- Complete 50 visits in a six (6) month period.

In order to obtain reimbursement, at the end of the six (6) month period, You must submit:
- A completed reimbursement form and a copy of Your current facility bill which shows the fee paid for Your membership for prior six (6) months.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of $200 or the actual cost of the membership per six (6) month period. Reimbursement must be requested within 120 days of the end of the six (6) month period. Reimbursement will be issued only after You have completed each six (6) month period even if 50 visits are completed sooner.

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SECTION XV

Routine Vision Care

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Routine Vision Care.
We Cover emergency, preventive and routine vision care.

B. Vision Examinations.
We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time per Plan Year, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.
We Cover standard prescription lenses or contact lenses one (1) time per Plan Year, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time per Plan Year, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non–standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non–standard frame. The difference in cost does not apply toward Your Out–of–Pocket Limit.

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SECTION XVI

Dental Care

Please refer to the Schedule of Benefits section of this Contract for Cost–Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services:

A. Emergency Dental Care.
We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care.
We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:
- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals.
- Topical application of fluoride at six (6) month intervals

C. Routine Dental Care.
We Cover routine dental care provided in the office of a dentist, including:
- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X–rays, full mouth x–rays or panoramic x–rays at 36–month intervals, bitewing x–rays at six (6) intervals, and other x–rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- Amalgam, composite restorations and stainless steel crowns.

D. Endodontics.
We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required. Root Canal Therapy on molar teeth is generally not covered under this program.

E. Periodontics.
We Cover limited periodontic services. We Cover non–surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

F. Prosthodontics.
We Cover prosthodontic services as follows:
- Removable complete or partial dentures, including six (6) months follow–up care; and
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:
- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full compliment of natural, functional and/or restored teeth;

- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery.
We Cover non–routine oral surgery, such as partial and complete bony extractions, tooth re–implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Contract.

H. Orthodontics.
We Cover orthodontics, based on medical necessity, to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:
- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

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SECTION XVII

Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare–paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. 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.

C. 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 an 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.

D. 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 Contract. 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 Policy unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre–Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.
We do not Cover orthodontia services except as specifically stated in the Dental Care section of this Contract.

G. 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 Contract, or 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 Contract for non–investigational treatments. See the Utilization Review and External Appeal sections of this Contract for a further explanation of Your Appeal rights.

H. 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).

I. 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.

J. 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 .

K. 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 Contract.

L. 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).

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

N. 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.

O. Services Not Listed.
We do not Cover services that are not listed in this Contract as being Covered.

P. 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.

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

R. Services with No Charge.
We do not Cover services for which no charge is normally made.

S. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

T. 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.

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SECTION XVIII

Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Contract. Either You or the Provider must file a claim form with Us. If the Provider is not willing to file the claim form, You will need to file it with Us.

B. 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 (800) 223–7242 (TTY: 711) or visiting Our website at www.MolinaHealthcare.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 in the How Your Coverage Works section of this Contract or visiting Our website at www.MolinaHealthcare.com.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120–day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.
We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x–ray or imaging services furnished pursuant to a referral prohibited by Section 238–a(1) of the New York Public Health Law.

E. Claim Determinations.
Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Contract.

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 Contract.

F. Pre–Service Claim Determinations.

1. A pre–service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre–service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 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 Pre–Service Reviews.** With respect to urgent pre–service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48–hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post–Service Claim Determinations.

A post–service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post–service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45–day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e–mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e–mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

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SECTION XIX

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 (800) 223–7242 (TTY: 711), or in writing to file a Grievance. You may submit an oral Grievance in connection with 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. Assistance.
If You remain dissatisfied with Our Grievance determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1–800–206–8125 or write them at:
New York State Department of Health
Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237

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E–mail: managedcarecomplaint@health.ny.gov
Website: www.health.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

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SECTION XX

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, or for mental health and substance use disorder services, call (800) 223–7242 (TTY: 711). 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 (800) 223–7242 (TTY: 711) or visit Our website at www.MolinaHealthcare.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 earlier of the receipt of part of the requested information or 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 and in writing 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) and Your Provider, 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) and Your Provider, 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 one (1) business day of the receipt of part of the requested information or 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) and Your Provider 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) and Your Provider 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) and Your Provider 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. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **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.

5. **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 the clinical review tool 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 and Your Provider 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 and Your Provider 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 timeframes 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. Step Therapy Override Determinations.
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence–based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request should include supporting rationale and documentation from a Health Care Professional, demonstrating that:
    - The required Prescription Drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
    - The required Prescription Drug is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
    - You have tried the required Prescription Drug while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
    - You are stable on a Prescription Drug selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB–rated generic equivalent; or

- The required Prescription Drug is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45–day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45–day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45–day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48–hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. 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.

H. 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, in person, 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 include the name, address, and phone number of the person handling Your Appeal and, 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 at issue.

1. **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.

2. **Out–of–Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization 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 authorization 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.

I. 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.

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 the 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.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. 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

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SECTION XXI

External Appeal

A. 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 Contract; 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).

B. 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 "A" above.

C. 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 "A" 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.

D. 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 "A" 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.

E. Your Right to Appeal an Out–of–Network Authorization Denial to a Non–Participating Provider.
If We have denied coverage of a request for an authorization 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 "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) 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.

F. 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 Contract for more information on the formulary exception process.

G. 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 timeframe 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 Contract. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the 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 Contract 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.

H. 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.

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SECTION XXII

Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.
This Contract shall automatically terminate:

1. Upon Your death.

2. When You turn 65, Your coverage will end at the end of the month in which you turn 65 or become Medicare eligible.

3. When You become Medicaid eligible or enroll in the Medicaid Program, Your coverage will end at the end of the month in which you are determined to be Medicaid eligible.

4. When Your income exceeds 200% of the Federal Poverty Level, Your coverage will end at the end of the month in which your income has changed.

5. When You have had a change in immigration status that makes you eligible for other coverage, including Medicaid, and Your coverage will end at the end of the month before you are determined to be Medicaid eligible.

6. When You have enrolled in a different program through the NY State of Health Marketplace.

B. Termination by You.
You may terminate this Contract at any time by giving the NYSOH at least 14 days' prior written notice.

C. Termination by Us.
We may terminate this Contract with 30 days' written notice as follows:

1. Non–Payment of Premiums.
   Premiums are to be paid by You to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
   - If You fail to pay the required Premium within a 30–day grace period, this Contract will terminate on the last day of the 30–day grace period. You will not be responsible for paying any claims submitted during the grace period if this Contract terminates.

2. Fraud or Intentional Misrepresentation of Material Fact.
   If You have performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on Your enrollment application, or in order to obtain coverage for a service, this Contract will terminate immediately upon a written notice to You from the NYSOH. However, if You make an intentional misrepresentation of material fact in writing on Your enrollment application, We will rescind this Contract if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Contract.

3. If You no longer live or reside in Our Service Area.

4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide You with at least 90 days prior written notice.

5. The date the Contract is terminated because We terminate or cease offering all hospital, surgical and medical expense coverage in the individual market, in this State. We will provide You with at least 180 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Conversion Right to a New Contract after Termination section of this Contract for Your right to conversion to another individual Contract.

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SECTION XXIII

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and

2. You serve no more than five (5) years of active duty.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and

2. Remit the premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

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SECTION XXIV

General Provisions

1. **Agreements Between Us and Participating Providers.**
   Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Subscriber as a patient. We do not guarantee a Subscriber's admission to any Participating Provider or any health benefits program.

2. **Assignment.**
   You cannot assign any benefits under this Contract or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Contract to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. See the How Your Coverage Works section of this Contract for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Contract 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. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. **Changes in this Contract.**
   We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. **Choice of Law.**
   This Contract shall be governed by the laws of the State of New York.

5. **Clerical Error.**
   Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Conformity with Law.**
   Any term of this Contract which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. **Continuation of Benefit Limitations.**
   Some of the benefits in this Contract may be limited to a specific number of visits. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, Your coverage terminates and you enroll in the product later in the year.

8. **Entire Agreement.**
   This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

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9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non–Participating Providers could be balance billed by the Non–Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
You will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Contract. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

12. Incontestability.
No statement made by You in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract. After two (2) years from the date of issue of this Contract, no misstatements, except for fraudulent misstatements made by You in the application for coverage, shall be used to void the Contract or deny a claim.

13. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. Input in Developing Our Policies.
You may participate in the development of Our policies. We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at (800) 223–7242 (TTY: 711) to find out how you can help.

15. Material Accessibility.
We will give You ID cards, Contracts, riders and other necessary materials.

16. More Information about Your Health Plan.
You can request additional information about Your coverage under this Contract. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Subscriber information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Contract.

- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Contract.

17. Notice.

Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your ID card.

18. Premium Payment.

The initial Premium is payable one (1) month in advance by the Subscriber to Us at Our office. The first month's Premium, if any, is due and payable upon submission of the application. Coverage will begin on the effective date of the Contract as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter.

19. Premium Refund.

We will give any refund of Premiums, if due, to You.

20. Recovery of Overpayments.

On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Renewal Date.

The renewal date for this Contract is 12 months after the effective date of this Contract. This Contract will automatically renew each year on the renewal date, as long as you remain eligible under the Contract and unless otherwise terminated by Us as permitted by this Contract.

22. Reinstatement after Default.

If You default in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

23. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Contract. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the

standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

24. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

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

26. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Contract as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

27. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness 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 Contract. 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, illness, 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, illness 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.

28. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Contract and nothing in this Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason

of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

29. 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 Contract. You must start any lawsuit against Us under this Contract within two (2) from the date the claim was required to be filed.

30. Translation Services.
Translation services are available under this Contract for non–English speaking Subscribers. Please contact Us at (800) 223–7242 (TTY: 711) to access these services.

31. Venue for Legal Action.
If a dispute arises under this Contract, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

32. Waiver.
The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

33. Who May Change this Contract.
This Contract 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 Contract 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.

34. Who Receives Payment under this Contract.
Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non–Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non–Participating Provider, We will pay the Non–Participating Provider directly. See the How Your Coverage Works section of this Contract for more information about surprise bills.

35. Workers' Compensation Not Affected.
The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

36. Your Medical Records and Reports.
In order to provide Your coverage under this Contract, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract, except as prohibited by state or federal law, You automatically give Us or Our designee

permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, and other authorized federal, state and local agencies with authority over the Essential Plan, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements. If You want to take away any permissions you gave to release this information, you may call us at (800) 223–7242 (TTY: 711).

37. Your Rights and Responsibilities.

As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

You have the right to access Our Participating Providers.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Contract. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Contract.

For additional information regarding Your rights and responsibilities, You can call Us at (800) 223–7242 (TTY: 711) to request a copy. If You need more information or would like to contact Us, please go to Our website at www.MolinaHealthcare.com or call Us at (800) 223–7242 (TTY: 711).

MOLINA HEALTHCARE
Your Extended Family.

Section XXV

Coverage for Contraceptive Drugs and Devices and Family Planning Services

A. General.

This rider amends the benefits of Your Contract and provides Coverage for the following:

- We Cover contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA. The contraceptive drug or device must be prescribed for You by a Provider that is legally authorized to prescribe pursuant to applicable law. You may have an initial three (3) month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You can have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Certain contraceptive drugs and devices may require an office visit, such as drugs or devices that require injection or insertion. We also Cover family planning services which consist of FDA–approved contraceptive methods prescribed by a Provider, counseling on the use of contraceptives and related topics, and sterilization procedures for women. Such contraceptive drugs or devices, office visits, family planning services and sterilization procedures 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 Cover vasectomies subject to Copayments, Deductibles or Coinsurance.
- We do not Cover services related to the reversal of elective sterilizations.

B. Controlling Contract.

All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

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Section XXVI

Coverage for Medically Necessary Abortions

A. General.

This rider amends the benefits of Your Contract and provides Coverage for the following:

- We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. This coverage is not administered by Your employer. Such coverage is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider. If You have any questions, please call (800) 223–7242 (TTY:711).

B. Controlling Contract.

All of the terms, conditions, limitations, and exclusions of Your Contract to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

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ESSENTIAL PLAN SECTION XXVII

Molina Healthcare of New York, Inc. SCHEDULE OF BENEFITS
See Benefit Description in Contract for More Details

Non–Participating Provider services are not Covered for any services other than those related to emergency care and You pay the full cost for services performed by a non–participating provider except in cases related to emergency care.

COST–SHARING	**ESSENTIAL PLAN 1**
Deductible • Individual	$0
Out–of–Pocket Limit • Individual	$2,000
Deductibles, Coinsurance and Copayments that make up Your Out–of–Pocket Limit accumulate on a Plan Year basis	
OFFICE VISITS	
Primary Care Office Visits (or Home Visits)	$15
Specialist Office Visits (or Home Visits)	$25
PREVENTIVE CARE	
• Adult Annual Physical Examinations*	Covered in full
• Adult Immunizations*	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full
• Sterilization Procedures for Women*	Covered in full
• Vasectomy	Use Cost–Sharing for Surgical Services
• Bone Density Testing*	Covered in full

• Screening for Prostate Cancer
  • Performed in PCP Office
  • Performed in Specialist Office
	
	Covered in full
	Covered in full

• All other preventive services required by USPSTF and HRSA	Covered in full
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost–Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
EMERGENCY CARE	
Pre–Hospital Emergency Medical Services (Ambulance Services)	$75

Non–Emergency Ambulance Services Preauthorization required	$75 Preauthorization required
Emergency Department Copay waived if admitted to Hospital	$75 Health care forensic examinations performed under Public Health Law § 2805–i are not subject to Cost–Sharing
Urgent Care Center Preauthorization required for out–of–network Urgent Care	$25 Preauthorization required for out–of–network Urgent Care
PROFESSIONAL SERVICES and OUTPATIENT CARE	
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed in a Specialist Office • Performed as Outpatient Hospital Services Preauthorization required	 $25 $25 $25 Preauthorization required
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $15 $25
Ambulatory Surgical Center Facility Fee Preauthorization required	$50 Preauthorization required
Anesthesia Services (all settings)	Covered in full
Autologous Blood Banking Preauthorization required	5% coinsurance Preauthorization required
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $25 $25 Included as part of inpatient Hospital service Cost–Sharing

Chemotherapy
• Administration
  • Performed in a PCP Office
  • Performed in a Specialist Office
  • Performed as Outpatient Hospital Services
  • Performed at home
• Chemotherapy Medication
 	
Preauthorization required
	
	$15
	$15
	$15
	$15
	$15
	
	Preauthorization required

Chiropractic Services	$25

MOLINA HEALTHCARE
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Clinical Trials Preauthorization required	Use Cost–Sharing for appropriate service Preauthorization required
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services Preauthorization required	 $15 $25 $25 Preauthorization required
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	 $15 $15 $15
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialty Office • Performed in an Outpatient Facility 60 visits combined per condition per plan year	 $15 $15 $15
Home Health Care 40 visits Per Plan Year Preauthorization required	$15 Preauthorization required
Infertility Services Preauthorization required	Use Cost–Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization required

Infusion Therapy
• Administration
  • Performed in a PCP Office
  • Performed in Specialist Office
  • Performed as Outpatient Hospital Services
  • Home Infusion Therapy
• Infusion Therapy Medication
(Home infusion counts toward home health care visit limits)
 	
Preauthorization required
	
	$15
	$15
	$15
	$15
	$15
	
	Preauthorization required

Inpatient Medical Visits Preauthorization required	$0 per admission Preauthorization required

Interruption of Pregnancy • Medically Necessary Abortions (Unlimited) • Elective Abortions (One (1) procedure per Plan Year)	 Covered in full Use Cost–Sharing for Ambulatory Surgical Center Facility Fee
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services Preauthorization required: Genetic Testing	 $15 $25 $25 $25 Preauthorization required: Genetic Testing
Maternity and Newborn Care • Prenatal Care • Inpatient Hospital Services One (1) home care visit covered at no Cost–Sharing if mother is discharged from Hospital early • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps covered for duration of breast feeding • Postnatal Care	 $0 $150 per admission $50 $0 Included in Physician and Midwife Services for Delivery Cost–Sharing
Outpatient Hospital Surgery Facility Charge Preauthorization required	$50 Preauthorization required
Preadmission Testing	$0
Prescription Drugs Administered in Office or Outpatient Facilities • Administration • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities • Prescription Drug Cost–Sharing Preauthorization required	 $15 $25 $25 $15 Preauthorization required
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services Preauthorization required	 $15 $25 $25 $25 Preauthorization required

Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services Preauthorization required: Radiation Therapy	 $15 $15 $15 Preauthorization required: Radiation Therapy
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $15 $15 $15
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$25
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants) All transplants must be performed at designated Facilities • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery Preauthorization required: All transplants	 $50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office Preauthorization required: All transplants
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	
ABA Treatment for Autism Spectrum Disorder	$15
Assistive Communication Devices for Autism Spectrum Disorder	$15
Diabetic Equipment, Supplies and Self–Management Education • Diabetic Equipment, Supplies and Insulin (30–day; Up to a 90 supply) • Diabetic Education	 $15 $15
Durable Medical Equipment and Braces Preauthorization required	5% Cost–Sharing Preauthorization required
External Hearing Aids (Single purchase one every three (3) years)	5% Cost–Sharing

Cochlear Implants (One (1) per year per time Covered) Preauthorization required	5% Cost–Sharing Preauthorization required
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	 $0 $0
Medical Supplies	5% coinsurance
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements • Internal Preauthorization required: All prosthetic devices	 5% coinsurance Included as part of Inpatient Hospital Cost–Sharing Preauthorization required: All prosthetic devices
INPATIENT SERVICES and FACILITIES	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) Preauthorization required	$150 Preauthorization required
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$75
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility Preauthorization required	$150 Preauthorization required

Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies Preauthorization required	$150 Preauthorization required
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 per Plan Year combined Preauthorization required	$150 Preauthorization required
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization required	$150 Preauthorization required
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All other Outpatient Services Preauthorization required	 $15 $15 Preauthorization required
Inpatient Substance Use Services Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS–certified facilities	$150 Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS–certified facilities
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) Up to 20 visits per Plan Year may be used for family counseling Preauthorization required	$15 Preauthorization required
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost–Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy	

Retail Pharmacy	
30–day supply Tier 1 Tier 2 Tier 3 If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal	 $6 $15 $30
Mail Order Pharmacy	
Up to a 90–day supply Tier 1 Tier 2 Tier 3	 $15 $37.50 $75
Enteral Formulas Tier 1 Tier 2 Tier 3	 $6 $15 $30
WELLNESS BENEFITS	
Gym Reimbursement	Up to $200 per six (6) month period
DENTAL and VISION CARE	
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics) One (1) dental exam and cleaning per six (6) month period. Full mouth x–rays or panoramic x–rays at 36–month intervals and bitewing x–rays at six (6) to 12–month intervals Orthodontics and major dental require Preauthorization	 $15 $15 $15 Orthodontics and major dental require Preauthorization

Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year	 $15 10% coinsurance 10% coinsurance

All in–network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Contract, You will be responsible for the full cost of the services.

Eligible American Indians/Alaska Natives, as determined by NYSOH, are exempt from Cost Sharing requirements, including when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through a Referral under the Purchased/Referred Care (PRC) program, formerly known as the Contract Health Services (CHS).