March 3, 2014



CATHY LOZIER
474 BROADWAY
CITY HALL
SARATOGA SPRINGS, NY 12866

Group # 10007332
Effective: January 01, 2014

Dear Cathy Lozier:

Thank you for choosing Capital District Physicians' Health Plan, Inc. to meet your employees' health care needs. We appreciate your business and look forward to a long-standing relationship with you and City of Saratoga Springs.

Enclosed are the contract for the benefits you selected, two title pages, and the applicable riders.**Please note: To ensure proper administration of your group, one copy of the contract title page must be signed by the appropriate representative and returned to our office within 10 days of receipt of this letter** in the enclosed postage-paid envelope.

Please contact the broker client services department at (518) 641-5000 if you have any questions or need additional information.

Sincerely,

Sales and Marketing
Capital District Physicians' Health Plan, Inc.

Enclosures

00170175

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.**
**500 Patroon Creek Boulevard**
**Albany, New York 12206-1057**

# CONTRACT

This Contract provides a prepaid health care program, to the extent hereinafter defined and limited to:

Group: City of Saratoga Springs

Group #: 10007332 Division: _____

This Contract is issued by the Capital District Physicians' Health Plan, Inc. (hereinafter referred to as "CDPHP")

This Contract between the Group and CDPHP entitles the enrolled, eligible Members to receive the benefits as hereinafter set forth for the period January 01, 2014 to December 31, 2014. The Group is responsible for providing to CDPHP timely and accurate notification of any Member's change in eligibility. Coverage is conditioned upon the terms set forth in the attached Subscriber Contract and any attached Riders, all as amended from time to time, as well as the underwriting guidelines filed with the premium rates listed below.

| | |
|---|---|
| Individual Premium..... | $651.96 |
| Subscriber and One Dependent..... | $1303.91 |
| Subscriber and Children..... | N/A |
| Family Premium..... | $1695.10 |

Contract: HMO $10 Copay Plan

**Riders #: HMRXL3G14, HMDMEL214, HMUNNL114, HMVSNL614, HMWWREMV14**

**Waiting period for new hires:**

**No wait - effective date of hire**

Capital District Physicians' Health Plan

DATE: March 3, 2014 BY: _____
Brian J. Morrissey, SVP, Marketing & CMO

City of Saratoga Springs

DATE: _____ BY: _____
Authorized Signature of Group

_____
Print Name and Title

**Premium Payment**

**A. Computation.**

CDPHP shall calculate the premium based upon its records of the number and Coverage of Members as of the 15th day of the month preceding the date that the next month's premium is due and payable. CDPHP shall provide the Group with written notice of the premium payable to CDPHP at least one (1) week prior to the date the premium is payable to CDPHP. The Group agrees to promptly notify CDPHP of the deletion or addition ofany Members Covered or to be Covered by CDPHP.

CDPHP and the Group shall cooperate to complete any retroactive adjustments to the premium necessary as a result of the addition or termination of Members Covered by CDPHP. CDPHP shall not be required to make aretroactive adjustment if the Group fails to notify CDPHP of the addition or termination of a Member' s Coverage within the timeframe agreed upon by the Group and CDPHP. If a Member is added to or terminated from theGroup's Contract during the period from the first (1) to the 15th day of any month, the premium will be retroactively adjusted as of the first (1) day of that month. If a Member is added to or terminated from the Group' s Contract during the period from the 16th day of any month to the last day of that month, the premium will not be retroactively adjusted.

**B. Due Date**

All premiums are payable monthly in advance by the Group to CDPHP at its office address indicated on the cover page of the Contract. The Group will arrange to collect any applicable Subscriber contributions for the premium directly from the Subscriber. The Group shall pay the total monthly premium due CDPHP on behalf of those Subscribers and any enrolled Dependents on or before the first day of any month during which Coverage is to be provided to those Subscribers and their enrolled Dependents. The first premiums are due and payable on the Group Effective Date of the Contract. Subsequent premiums are due and payable on the first of each Contract Month thereafter during the continuance of the Contract. The Group shall act as the agent for the Group's Subscribers and any enrolled Dependents and shall not, under any circumstances, be the agent, employee or representative of CDPHP in collecting any amounts from Subscribers and paying them to CDPHP.

CDPHP will provide the Group with at least 30 days' notice of the Group Effective Date of any premium increase or decrease approved by the State of New York.

A grace period of 15-days, from the due date, will be granted for the payment of any premium during the timethe Contract shall continue in force. If the premium is not paid within that 15-days period, Coverage of all MembersCovered by the Contract will be deemed to have terminated automatically as of the last date for which premium payments have been made, without notice from CDPHP to the Group or to the Members. CDPHP shall be entitled to notify Group Subscribers of the non-payment of premiums to enable them to make necessary arrangements topay for their Health Services upon termination of the Contract. The termination of the Contract shall not relievethe Group or Member of his/her or its obligation to pay premiums due for Coverage provided.

**C. Reinstatement**

If payment is accepted by CDPHP after the termination date and the Group is reinstated:

1. A reinstatement fee of $10 will be applied per Subscriber.

**D. Late Charges.**

Group shall pay to CDPHP a late charge of 16% per annum for any amount due and owing to CDPHP for late payment of any premiums paid after the due date. CDPHP will provide written notice to the Group policyholder for any late payment charges due to CDPHP.

No employee or agent of CDPHP other than senior management is authorized to:

1. Accept any payment of premiums after the expiration of the grace period; or
2. Waive any lateness of any payment.

**E. Termination of Contract**

CDPHP or Group may terminate the Contract at the end of any month by giving the other party at least 31 days' written notice of termination prior to the Effective Date of termination. **CDPHP will only terminate the Contract based upon one or more of the following:**

1. **Nonpayment or late payment of premiums by the Group, in which case the requirement to provide 31 day's notice to the Group is superceded by the provisions set forth in Section B. above;**
2. **Fraud or intentional misrepresentation by the Group of material fact under the terms of the Contract;**
3. **CDPHP ceases to offer the Coverage under this Contract in the applicable market, and provides at least 90 days' written notice thereof to each Subscriber prior to the date of discontinuance of such Coverage;**
4. **CDPHP ceases to offer any Coverage in the applicable market and provides written notice thereof to each Member 180 days prior to the date of discontinuance in the applicable market;**
5. **There is no longer any Member Covered under the Contract who lives, resides or works in the Service Area;**
6. **Where the Policyholder ceases to meet the requirements of a Group or a participating employer, labor union, association or other entity ceases membership or participation in the Group to which this Contract is issued, but only if such Coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Covered individual.**

The Contract shall only be terminable at the end of any month. Termination of the Contract shall be without prejudice to any claim originating prior to the effective date of termination.

Upon termination of the Contract, the Group shall be liable to CDPHP for the payment of any and all premiums which are due but unpaid at the time of termination.

At the time of Coverage renewal, CDPHP may modify this Contract so long as such modification is consistent with applicable law and effective on a uniform basis among all small Group Contract holders with this Contract. Coverage renewal occurs when the Group renews the Coverage under this Contract.

Provision of benefits by CDPHP to Members is also conditioned upon the timely payment of the stipulated premium by the Group determined on the premium rates listed below. **These rates are guaranteed for the initial period set forth above. Rates may change for each successive one-year renewal period. CDPHP will provide written notification at least 30 days in advance of the effective date of any such rate change. Rate changes will be effective the first day of the one-year renewal period unless the Group terminates this contract pursuant to the terms of the attached Contract. The Group's payment of the rates listed below and any subsequent rate changes indicates its approval thereof.**

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.**
**500 Patroon Creek Boulevard**
**Albany, New York 12206-1057**

# CONTRACT

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Group: City of Saratoga Springs

Group #: 10007332 Division: _____

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Capital District Physicians' Health Plan

DATE: March 3, 2014 BY: _____
Brian J. Morrissey, SVP, Marketing & CMO

City of Saratoga Springs

DATE: _____ BY: _____
Authorized Signature of Group

_____
Print Name and Title

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**B. Due Date**

All premiums are payable monthly in advance by the Group to CDPHP at its office address indicated on the cover page of the Contract. The Group will arrange to collect any applicable Subscriber contributions for the premium directly from the Subscriber. The Group shall pay the total monthly premium due CDPHP on behalf of those Subscribers and any enrolled Dependents on or before the first day of any month during which Coverage is to be provided to those Subscribers and their enrolled Dependents. The first premiums are due and payable on the Group Effective Date of the Contract. Subsequent premiums are due and payable on the first of each Contract Month thereafter during the continuance of the Contract. The Group shall act as the agent for the Group's Subscribers and any enrolled Dependents and shall not, under any circumstances, be the agent, employee or representative of CDPHP in collecting any amounts from Subscribers and paying them to CDPHP.

CDPHP will provide the Group with at least 30 days' notice of the Group Effective Date of any premium increase or decrease approved by the State of New York.

A grace period of 15-days, from the due date, will be granted for the payment of any premium during the timethe Contract shall continue in force. If the premium is not paid within that 15-days period, Coverage of all MembersCovered by the Contract will be deemed to have terminated automatically as of the last date for which premium payments have been made, without notice from CDPHP to the Group or to the Members. CDPHP shall be entitled to notify Group Subscribers of the non-payment of premiums to enable them to make necessary arrangements topay for their Health Services upon termination of the Contract. The termination of the Contract shall not relievethe Group or Member of his/her or its obligation to pay premiums due for Coverage provided.

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No employee or agent of CDPHP other than senior management is authorized to:

1. Accept any payment of premiums after the expiration of the grace period; or
2. Waive any lateness of any payment.

**E. Termination of Contract**

CDPHP or Group may terminate the Contract at the end of any month by giving the other party at least 31 days' written notice of termination prior to the Effective Date of termination. **CDPHP will only terminate the Contract based upon one or more of the following:**

1. **Nonpayment or late payment of premiums by the Group, in which case the requirement to provide 31 day's notice to the Group is superceded by the provisions set forth in Section B. above;**
2. **Fraud or intentional misrepresentation by the Group of material fact under the terms of the Contract;**
3. **CDPHP ceases to offer the Coverage under this Contract in the applicable market, and provides at least 90 days' written notice thereof to each Subscriber prior to the date of discontinuance of such Coverage;**
4. **CDPHP ceases to offer any Coverage in the applicable market and provides written notice thereof to each Member 180 days prior to the date of discontinuance in the applicable market;**
5. **There is no longer any Member Covered under the Contract who lives, resides or works in the Service Area;**
6. **Where the Policyholder ceases to meet the requirements of a Group or a participating employer, labor union, association or other entity ceases membership or participation in the Group to which this Contract is issued, but only if such Coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Covered individual.**

The Contract shall only be terminable at the end of any month. Termination of the Contract shall be without prejudice to any claim originating prior to the effective date of termination.

Upon termination of the Contract, the Group shall be liable to CDPHP for the payment of any and all premiums which are due but unpaid at the time of termination.

At the time of Coverage renewal, CDPHP may modify this Contract so long as such modification is consistent with applicable law and effective on a uniform basis among all small Group Contract holders with this Contract. Coverage renewal occurs when the Group renews the Coverage under this Contract.

Provision of benefits by CDPHP to Members is also conditioned upon the timely payment of the stipulated premium by the Group determined on the premium rates listed below. **These rates are guaranteed for the initial period set forth above. Rates may change for each successive one-year renewal period. CDPHP will provide written notification at least 30 days in advance of the effective date of any such rate change. Rate changes will be effective the first day of the one-year renewal period unless the Group terminates this contract pursuant to the terms of the attached Contract. The Group's payment of the rates listed below and any subsequent rate changes indicates its approval thereof.**

# CDPHP HMO CERTIFICATE

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

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

This Certificate is issued to the person named on the Capital District Physicians' Health Plan, Inc. Identification Card. Coverage under this Certificate and the Contract begins on the Member Effective Date and it will continue unless it is terminated for any of the reasons hereinafter described.

# Capital District Physicians' Health Plan, Inc.

**By:**
**John D. Bennett, MD**
**President and CEO**

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.**
**500 Patroon Creek Boulevard**
**Albany, New York 12206-1057**
**(518) 641-3000**

# CDPHP HMO CERTIFICATE

# TABLE OF CONTENTS


| | | Page No. |
|---|---|---|
| **SECTION I:** | Introduction | 2 |
| **SECTION II:** | Definitions | 2 |
| **SECTION III:** | Eligibility, Enrollment and Conditions of Coverage | 5 |
| **SECTION IV:** | Covered Health Care Services | 9 |
| **SECTION V:** | Limitations of Coverage | 15 |
| **SECTION VI:** | Reimbursement of Expenses for Treatment by Non-Participating Providers | 18 |
| **SECTION VII:** | Exclusions | 18 |
| **SECTION VIII:** | Conversion Privilege | 21 |
| **SECTION IX:** | Extension and Continuation of Coverage | 21 |
| **SECTION X:** | Coordination of Benefits ("COB") | 23 |
| **SECTION XI:** | Right of Recovery | 24 |
| **SECTION XII:** | Relationship Between Parties | 24 |
| **SECTION XII:** | General Provisions | 25 |


# SECTION I—INTRODUCTION

The Capital District Physicians' Health Plan, Inc. (CDPHP) hereby agrees with the Group to provide Coverage for the Health Services set forth herein to Members, subject to the exclusions, limitations, conditions and other terms of the Contract.

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

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

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

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

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

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

Services are Covered only when Medically Necessary.

Information regarding utilization review, external appeals, and grievance procedures appears in your HMO member handbook.

# SECTION II—DEFINITIONS

1. **Accidental Dental**: care for trauma to a sound natural tooth caused by something other than a natural function such as chewing and grinding of the teeth.
2. **Accidental Injury**: an unforeseen and unintended injury.
3. **Active Treatment**: treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health.
4. **Adoptive Child:** a child or infant on whose behalf a Member is actively engaged in adoption proceedings, but such proceedings have not yet been completed.

5. **Application/Change Form:** the form completed by a potential Subscriber requesting Coverage from CDPHP and listing all Dependents to be Covered on the date such Coverage takes effect, or Members who wish to add or delete Dependents or terminate Coverage.
6. **Benefit Period:** the 12-month period indicated on the Group Contract title page.
7. **Biologically Based Mental Illness**: a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such illnesses are defined as: schizophrenia/psychotic disorders, major depression, bi-polar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, anorexia.
8. **COBRA:** Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
9. **Calendar Year:** is a 12-month period beginning January 1 and ending December 31 of each year.
10. **Certificate**: the document issued to a Subscriber which sets forth the terms, conditions and limitations of CDPHP's Coverage. Certificate shall include this Contract and a cover page entitled "Certificate".
11. **Children With Serious Emotional Disturbances:** those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.
12. **Claim Form**: the form provided by CDPHP for incurred Eligible Expenses for treatment by non-Participating Providers as explained in Section VI. of the Contract.
13. **Coinsurance:** a charge, in addition to the premium, which the Member is required to pay for certain Health Services provided under the Contract. It is expressed as a percentage of the fee for Health Services. The Member is responsible for the payment of any Coinsurance charge directly to the provider at the time that Health Services are provided.
14. **Continuous Confinement:** consecutive days of in-Hospital service received as an inpatient, or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days, or successive confinements due to the same or related causes unless between such confinements a Covered person has been actively at work, if an employee, or engaged in normal activity if not an employee, for a period of 90 days. A confinement for an Accidental Injury shall not be combined with another confinement for an illness in determining continuous Hospital confinement.
15. **Contract:** the fully signed and executed agreement entered into between CDPHP and the Group on behalf of eligible enrolled Members. The Contract shall include the Group Contract title page, this form, the accompanying Schedule of Benefits, and any applicable Riders.
16. **Contract Month**: a period commencing on the first day of each calendar month and ending the last day of that month.
17. **Conversion Privilege:** the privilege given to Members to convert to a non-Group Contract on termination of Group Coverage without evidence of insurability as described in Section VIII herein.
18. **Copayment:** a charge, in addition to the premium, which the Member is required to pay per visit for certain Health Services provided under the Contract. It is expressed as a fixed dollar amount payable each time a given Health Service is provided regardless of the number of times it is provided. The Member is responsible for the payment of any Copayment directly to the provider when Health Services are provided.
19. **Coverage or Covered:** the Health Services paid for under the Contract.
20. **Dependent**: a person other than the Subscriber meeting all relevant applicable eligibility requirements set forth in Section III.A.2. of the Contract, and for whom the monthly premium has been received by CDPHP.
21. **Diagnosis:** an act or process of identifying or determining the nature of disease or injury through examination or testing.
22. **Durable Medical Equipment or DME**: items which can withstand repeated use, are primarily used to serve a medical purpose and not merely for convenience, are generally not useful to a person in the absence of illness, injury or disease and are appropriate for use in the home.
23. **Elective Admission**: any admission that could be scheduled more than 24 hours in advance without putting the patient's health in serious jeopardy.
24. **Eligible Expenses:** the fees for Health Services Covered under the Contract. Eligible Expenses only include fees for services actually provided to Members.
25. **Emergency Condition.** A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    1. 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;
    2. Serious impairment to such person's bodily functions;
    3. Serious dysfunction of any bodily organ or part of such person; or
    4. Serious disfigurement of such person.
26. **Emergency Services:** a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an 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. This definition is not intended to limit the scope of services to treat an Emergency Condition otherwise covered under the Contract.
27. **Family Coverage:** includes Coverage for Subscriber and any Dependents.

28. **Formulary:** The list of Prescription Drugs that are Covered under your benefit.
29. **Group**: the employer, association or other entity which contracts with CDPHP to provide Health Services to Members.
30. **Group Benefit Plan:** a health benefit plan such as HMO Coverage, health insurance, employer self-insurance or other Group health plan that covers a Subscriber or Dependent as part of the Group.
31. **Group Effective Date:** the date agreed to by the Group and CDPHP upon which the Group is entitled to enroll Members to receive Health Services from CDPHP.
32. **Health Services/Health Care Services**: services to treat Accidental Injuries or sickness, or Medically Necessary preventive care. Health Services do not include services which are not actually provided to Members.
33. **Home Health Care**: a program of care provided by an agency engaged in providing Home Health Care Services including, but not limited to, skilled nursing services and having a valid existing agreement with CDPHP to provide said services to Members.
34. **Hospice Care:** the care and treatment of a Member who has been certified by his/her Primary Care Physician as having a life expectancy of six months or less and which is provided by a hospice organization certified under the New York Public Health Law or under a similar certificate process required by the state in which the hospice is located.
35. **Hospital:** an acute general care facility operated pursuant to law which: (a) is primarily engaged in providing diagnostic therapeutic services for surgical or medical Diagnosis, treatment, and care of injured and sick persons by, or under the supervision of, a staff of physicians; (b) has 24-hour nursing services by registered professional nurses; and (c) is not (other than incidentally) a place for rest, custodial care or the aged; or a nursing home, convalescent home or similar institution.
36. **Identification or ID Card:** the card that CDPHP issues to its Members showing that they are entitled to receive Health Services from Participating Practitioners and Providers under the terms of the Contract.
37. **Individual Coverage:** refers to Coverage for Subscriber only.
38. **Lifetime Maximum**: the total Allowed Amount for Covered Benefits that CDPHP will pay per Member per Lifetime pursuant to the Group Contract.
39. **Medically Necessary**: those Health Services defined by CDPHP's Medical Director, or his/her designee, that are necessary to prevent, treat and/or alleviate symptoms of an illness, disorder, or condition, are rendered at an appropriate level of intensity, can reasonably be expected to promote effective outcomes, are expected to provide significant, measurable clinical improvement within a reasonable and medically predictable period of time, are provided efficiently and facilitate quality of care. More specifically, this includes treatments needed to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life resulting in illness or infirmity, interfere with such person's ability for normal activity, or threaten a major handicap.
40. **Medical Supplies:** items other than drugs, prosthetic or orthotic appliances, or DME used for the treatment of a specific medical condition which are consumable, non-reusable, disposable, and generally have no salvageable value (i.e. diapers, gauze pads, bandages).
41. **Medicare:** the Health Insurance for Aged and Disabled Program established pursuant to Title XVIII of the Federal Social Security Act, as it is in effect at the Group Effective Date of the Contract or as that act may be subsequently amended.
42. **Member:** a Subscriber and/or Dependent.
43. **Member Effective Date:** the date from which Members are entitled to receive Health Services from CDPHP.
44. **Mental Health Care:** Care rendered by an eligible practitioner or approved facility and which in the opinion of CDPHP, is directed predominantly at treatable behavioral manifestations of a condition that CDPHP determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
45. **Non-Covered Service:** the Health Services not Covered under the Contract.
46. **Non-Group Contract:** a Contract issued by CDPHP directly to a Member, in accordance with the Conversion Privilege described in Section VIII of the Contract, or for any other reason, which requires the Member to pay the premium directly to CDPHP for that Contract.
47. **Open Enrollment Period:** a period during which subscribers in a health benefit program have an opportunity to select an alternate health plan being offered to them, or a period when uninsured employees and their dependents, if any, may obtain Coverage without presenting evidence of insurability.
48. **Participating Practitioner:** any licensed practitioner who has agreed under contract to provide Health Services to Members.
49. **Participating Provider:** any Hospital, Skilled Nursing Facility, Home Health Care agency, ambulance service, Urgent Care Center, Ambulatory Surgical Center, DME vendor, laboratory or other health care provider that has agreed under contract to provide Health Services to Members.
50. **Physical Therapy:** therapy which can result in significant clinical improvement in a Member's condition.
51. **Primary Care Physician**: a Participating Practitioner physician who agrees under contract with CDPHP to assume primary responsibility for coordinating the overall health care of CDPHP Members. Each Member must choose a Primary Care Physician who is a Participating Practitioner physician practicing in a primary care specialty as defined by CDPHP. A Member must notify CDPHP of any change in Primary Care Physician prior to or within 5 days after any services are rendered by the newly selected PCP. If a Member does not notify CDPHP of their change in PCP within 5 days of the services being rendered, the Member will be responsible for the cost of those services.
52. **Rider:** an agreement purchased by the Group which amends the Contract to provide Members with Coverage for additional and/or reduced Health Services. All Riders which apply to the Contract are attached to the Contract on the Group Effective Date of Coverage.
53. **Schedule of Benefits**: the document attached to this Certificate which describes the benefits available under this Contract and any applicable Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Lifetime Maximums and other Coverage information.

54. **Semi-Private Room:** a room with two or more beds in a Hospital, Skilled Nursing Facility or other health care facility.
55. **Service Area:** the geographic area approved by the New York State Health Department in which CDPHP has arranged to provide Health Services to Members.
56. **Short-Term Therapy**: therapy that is anticipated to achieve measurable and practical goals in 60 days or less.
57. **Skilled Nursing Facility:** a facility providing therapeutic services to inpatients requiring medical and skilled nursing care as defined under Section 2801 of the Public Health Law and which is qualified to participate as an extended care facility under Title XVIII of the Social Security Act.
58. **Subscriber:** any person, other than a Dependent, who meets all relevant applicable eligibility requirements under Section III.A.1. of the Contract, who applies and is accepted for Coverage from CDPHP, and for whom the monthly premium has been received by CDPHP.
59. **Substance Use Disorder:** Substance Use Disorder means a disorder involving alcohol and substance use that falls as listed in the mental disorders section of the International Classification of Disease (ICD-CM-9) or the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.
60. **Surgical Procedures:** those medical procedures consisting of: (a) operating procedures for the Diagnosis and treatment of an illness or injury; (b) endoscopies; (c) correction of dislocations; (d) treatment of fractures; and (e) any puncture or incision of tissue or skin requiring the use of surgical instruments, including any pre- and post-operative care usually rendered in connection with such operation or procedure.
61. **Totally Disabled:** a condition when, by reason of Accidental Injury or illness, a working Member is incapable of performing tasks of any employment. In the case of a non-working Member when, by reason of injury or illness, he/she is wholly unable to engage in the normal activities of a person of the same sex and age.
62. **Urgent Care Facility**: a licensed facility which provides medical assistance to treat minor and non-life-threatening Accidental Injuries, illnesses, disorders or conditions.

# SECTION III—ELIGIBILITY, ENROLLMENT AND CONDITIONS OF COVERAGE

**A. Eligibility.**

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

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

   Medicare eligible Members over 65 who are employees of a Group with less than 20 employees, or a retiree of a Group with more than 20 employees, must obtain Medicare Part A (Hospital) and Part B (medical). A copy of the Member's Medicare card must be provided to CDPHP prior to enrollment.
   f. In the event of a Group offering other CDPHP Benefit Plan options to Medicare-eligible employees and/or retirees in addition to the Coverage provided under this Contract, and a Medicare eligible employee and/or retiree enrolls in such CDPHP benefit plan option, any individual who is otherwise eligible to enroll as the Subscriber's Dependent spouse is eligible to enroll as the Subscriber for the purposes of this Contract, subject to all of the terms and conditions of this Contract, except for items "b" through "e" above, provided that the Dependent spouse is not Medicare-eligible. Dependent children of the Subscriber's Dependent spouse are also eligible to remain enrolled. Any Dependent spouse enrolled as a Subscriber under this Section A.1.i is still considered a Dependent spouse for the purposes of this Section III (Eligibility, Enrollment and Conditions of Coverage) and Section IX (Extension and Continuation of Coverage).
2. Dependents: To be eligible to enroll as a Dependent, an individual must either be:
   a. Married to the Subscriber;
   b. An unmarried child of the Subscriber, including any stepchild, legally adopted child or proposed Adoptive Child, who is:
      i. Dependent upon the Subscriber for support and maintenance;
      ii. Less than 19 years of age; and
      iii. Not on active duty in the armed forces of any country;
   c. Adoptive non-infant children are considered Dependents upon the date CDPHP receives notification and payment for additional premium, if any, provided that the following steps resulting in final adoption are completed:
      i. The Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of taking physical custody;
      ii. No notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and

iii. Consent to the adoption has not been revoked.

If CDPHP is not notified of and/or does not receive payment of any additional applicable premium for an Adoptive Child on or before the 31st day from the date of birth or the date the child is physically in the household of the Member, then Coverage will not begin until the Group's next Open Enrollment Period;

d. Newly-born infants adopted by the Member or Subscriber are Covered from the moment of birth when the following steps resulting in final adoption are completed:
   i. CDPHP is notified of the infant's birth within 31 days of the date of birth;
   ii. The Subscriber takes physical custody of the adoptive infant upon release from the Hospital;
   iii. The Subscriber files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of birth;
   iv. No notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and
   v. Consent to the adoption has not been revoked.

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

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

**B. Enrollment.**

1. Subscribers may join CDPHP, only on the Group's anniversary date, upon meeting the eligibility requirements imposed by the Group and agreed to by CDPHP, or during special Open Enrollment Periods agreed upon by both the Group and CDPHP.
2. Newly hired employees may enroll upon meeting the eligibility requirements imposed by the Group and agreed to by CDPHP. The Group agrees to give all employees or Members of the Group the CDPHP Application/Change Form and descriptive literature as soon as they become eligible for Coverage. Such persons may apply for Coverage from CDPHP within 31 days of the date they become eligible for Coverage. If such persons do not apply within 31 days of the date they become eligible, they must wait until the Group's next Open Enrollment Period to become Covered.
3. Coverage will begin as follows:
   a. If the potential Subscriber files an Application/Change Form with CDPHP before becoming eligible for Coverage, his/her Coverage starts on the date such person becomes eligible.
   b. If the potential Subscriber files an Application/Change Form with CDPHP within 31 days after his/her date of eligibility, Coverage starts on the date such person became eligible.
   c. If a Subscriber marries and files an Application/Change Form with CDPHP within 31 days after the marriage indicating that he/she wants Family Coverage, Coverage for such Dependents starts on the date of the marriage.
   d. If a Member gives birth to or adopts a child and has Family Coverage, Coverage for the child starts on the date the child is born or adopted, provided that the Member submits an Application/Change Form to CDPHP within 31 days

of the birth or adoption. If the Member does not have Family Coverage, Coverage for the child will still begin on the date of the birth or adoption if the Member submits an Application/Change Form requesting Family Coverage to CDPHP within 31 days of the birth or adoption.

4. When You Reject Initial Enrollment Or Elect Not To Enroll During Open Enrollment.
   If the Subscriber rejects initial enrollment under this Certificate, or elects not to enroll during a subsequent open enrollment, you may enroll for coverage if the following conditions are met:
   a. You or your dependent had coverage under another plan or contract when coverage was initially offered or at a subsequent open enrollment period; and
   b. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you or your dependent lost eligibility for one or more of the following reasons:
      1. Termination of employment;
      2. Termination of the other plan or contract;
      3. Death of the spouse;
      4. Legal separation, divorce or annulment;
      5. Reduction in the number of hours worked;
      6. The employer or other group ceased its contribution toward the premium for the other plan or contract;
      7. The coverage was under an HMO, and you no longer live, work or reside in the HMO service area;
      8. Cessation of dependent child status;
      9. Benefits are no longer offered to similarly situated individuals (e.g., part-time employees); or
      10. The benefit maximum under the plan or contract has been reached
   c. You acquire a dependent due to birth, adoption, guardianship, placement for adoption or marriage, in which case you, the Subscriber, may enroll for individual coverage or for a type of coverage available to your group that will cover you and your eligible dependents; or
   d. You lose eligibility for coverage under Medicaid, Family Health Plus, or Child Health Plus, or you become eligible for State premium assistance under Medicaid, Family Health Plus, or Child Health Plus.
   e. You apply for coverage under this Certificate within 60 days after termination for one of the reasons set forth in Subparagraph B above or acquisition of a dependent as set forth in Subparagraph C above; or you apply for coverage under this Certificate within 60 days of the occurrence of an event set forth in Subparagraph D above.

   If you enroll for coverage pursuant to Subparagraphs A and B, or Subparagraph D, your coverage will begin at 12:01 a.m. on the first day of the month following the request for enrollment. If you enroll for coverage pursuant to Subparagraph C above, your coverage will begin at 12:01 a.m. on: the date of the birth, adoption, guardianship or placement for adoption; or on the first day of the month following the request for enrollment, when you are entitled to special enrollment based on marriage.

5. Special Enrollment Periods.
   a. CDPHP shall permit an employee who is eligible, but not enrolled, for Coverage under the terms of the Contract (or a Dependent of such an employee if the Dependent is eligible, but not enrolled, for Coverage under such terms) to enroll for Coverage under the terms of the Contract if each of the following conditions is met:
      i. The employee or Dependent was covered under a group health plan or had health insurance coverage at the time Coverage was previously offered to the employee or Dependent.
      ii. The employee's or dependent's coverage described in Section III.B.4.a.i. above:
         a. Was under a COBRA continuation provision and the coverage under such provision was exhausted; or
         b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce or annulment, death of a spouse, termination of employment, termination of the other plan or contract, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.
      iii. The employee requests such enrollment not later than 31 days after the date of exhaustion of Coverage described in Section III.B.4.a.ii.a. or termination of Coverage or employer contribution described in Section III.B.4.a.ii.b.
   b. If a person becomes a Dependent of a Member (or has met any waiting period applicable to becoming a Member and is eligible to be enrolled but for failure to enroll during a previous enrollment period) through marriage, birth, or adoption or placement for adoption, the person (or, if not otherwise enrolled, the individual) may be enrolled as a Dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a Dependent of the individual if such spouse is otherwise eligible for Coverage.

      A Dependent special enrollment period under this Section III.B.4.b. shall be a period of not less than 31 days and shall begin on the later of:
      i. The date Dependent Coverage is made available; or
      ii. The date of the marriage, birth, or adoption or placement for adoption (as the case may be)

      If an individual seeks to enroll a Dependent during the first 31 days of such a Dependent special enrollment period, the Coverage of the Dependent shall become effective:
      i. in the case of marriage, not later than the first day of the first month beginning after the date the completed CDPHP Application/Change Form is received;
      ii. in the case of a Dependent's birth, as of the date of such birth; or
      iii. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

CDPHP shall permit an employee and a dependent, who are eligible, but not enrolled, for coverage under the terms of the contract to enroll for coverage under the terms of the contract if the following conditions are met:

i. The employee or dependent lost eligibility for coverage under a State Medicaid, Family Health Plus or Child Health Plus program, or
ii. The employee or dependent has become eligible for State premium assistance under Medicaid, Family Health Plus or Child Health Plus; and
iii. The employee or dependent submits an application form to CDPHP within 60 days of being terminated from Medicaid, Family Health Plus or Child Health Plus coverage or within 60 days of being determined to be eligible for premium assistance.

**Full-Time Student Dependent**: A full-time student in a degree program at a postsecondary educational institution as found in Section 102 of the Higher Education Act of 1965; or, a full-time student participating in an extended course of study at a registered or licensed business or trade school leading to eligibility for licensure or certification in a vocation or technical field.

**Out of Service Area Benefit for Covered Student Dependents**

In addition to the Medically Necessary services Covered under the Contract, when a Covered student Dependent is attending school outside of CDPHP's Service Area, CDPHP will provide additional Coverage for the following:

i. Medically Necessary services rendered outside the CDPHP Service Area, subject to the prior approval requirement stated below.
ii. Coverage outside of the Service Area does not apply during vacations and/or summer recess. If a student Dependent is enrolled in classes required toward their elected course of study during periods usually deemed to be vacation and/or summer recess, Coverage outside of the Service Area as described in paragraph i. above will remain in effect.
iii. Preventive Care rendered outside the Service Area which is not for the purpose of treating a particular illness, injury or disease is excluded. Preventive Care will be Covered under the Contract only when it is provided or arranged by the Member's Primary Care Physician in the Service Area.
iv. Out of area coverage for student Dependents is not limited to students age 19 and older, as long as the other requirements stated in section III.A.2.h. are met.

**Prior Approval Requirement for Out of Service Area Coverage**

i. Except for Emergency care as provided by the Contract, prior approval must be obtained before services rendered to student Dependents out of the Service Area under this Contract
ii. If a student Dependent has an illness, injury or disease which
    a. Results in absence from classes for more than two consecutive school weeks or;
    b. Requires continued medical treatment for more than 60 days, then CDPHP reserves the right to require the student Dependent to return to CDPHP's Service Area to obtain Medically Necessary services from Participating Providers.

## C. Termination of Coverage

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

1. Upon the Group's failure to pay the required premium to CDPHP in accordance with the Contract title page.
2. The date that the Contract is terminated, or with respect to any specific Health Services Covered by the Contract, the date such Coverage terminates.
3. For Subscribers, the end of the month in which the Member ceases to be eligible as a Subscriber. For Dependent spouses in cases of divorce, the date of divorce. For all other Dependents, the end of the month in which the Dependent ceases to be eligible, unless the reason for ineligibility is that the Dependent child becomes married. In such cases, Coverage will terminate as of the date of the Dependent's marriage. If a Dependent ceases to be a full-time student, CDPHP must be notified immediately in writing.
4. The date on which the Subscriber ceases to meet eligibility requirements as defined by the Group or those requirements listed in Section III.A.1.
5. The date on which the Member no longer resides or works within the Service Area.
6. The end of the Contract Month during which the Group receives written notice from the Subscriber requesting termination of Coverage, or on such later date requested for such termination by the notice.
7. The end of the month in which the Subscriber is retired or pensioned, unless Coverage is specifically provided for retired or pensioned individuals by agreement between CDPHP and the Group.
8. If a Subscriber has made a fraudulent misrepresentation of material fact in writing on his/her Application/Change Form, Coverage shall terminate immediately upon written notice of termination delivered by CDPHP to the Group.
9. The date of entry into active military duty, except for temporary duty for 31 days or less. In the event of such termination, the Member may be entitled to supplementary conversion and continuation rights in addition to the conversion and continuation rights as described in Sections IX and X of this Contract. Nothing herein shall be interpreted to preclude the application of Insurance Law §4305(g) regarding supplementary conversion and continuation rights for members of a reserve component of the armed forces of the United States, including the National Guard, and their spouses and/or dependents.
10. If a Member fraudulently misrepresents a material fact in order to obtain Coverage for a non-Covered service, that Member's Coverage will terminate immediately upon receipt of written notice of termination by CDPHP to the Group.

If a Member's Coverage is to be terminated for the reasons described in "8" through "10" above, CDPHP shall notify the Member of the proposed termination of Coverage and the right to have the matter considered in accordance with CDPHP's Claims and Appeals procedure. It shall not notify the Group of such termination until a final decision is issued in accordance with that grievance procedure.

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

Notices of termination are provided with 30 days written notice in accordance with regulation 78.

# SECTION IV—COVERED HEALTH CARE SERVICES

**Health Care Services from Participating Practitioners and Providers and Approved non-Participating Practitioners and Providers.** No more than one applicable Visit Copayment will be required per practitioner and/or provider per day. **Refer to the accompanying Schedule of Benefits for the applicable Copayment and/or Coinsurance amounts.**

**A. Office Based Health Services.**

**Service**

1. Primary Care Office and Home Visits.
2. Annual physical for adults (over age 19) per Benefit Period including laboratory services directly related to the performance of the Routine physical exam.
   a. One non-gynecological Routine Physical exam per Benefit Period.
   b. One gynecological Routine physical exam per Benefit Period.

   Age limitation in Section IV.A.2. does not apply to routine gynecological exams.
3. Diagnostic Services, including, but not limited to:
   a. Radiology and Imaging Services.
      i. X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs and CT scans.
      ii. Other Surgical or Medical Diagnostic Radiology and Imaging Services
   b. Preventive services that include but are not limited to: Mammography, Colonoscopies, PSA screenings, Cervical Cytology
   c. Bone Mineral Density Measurements and Tests. Coverage is provided consistent with criteria under the federal Medicare program and the National Institutes of Health
   d. Electrocardiograms, Echocardiograms, and other Cardiology Testing
   e Spirometry, Pulmonary Function Tests and other Pulmonary Testing
   f Vascular Testing
   g. Electroencephalography, Electromyograms, Nerve Conduction Testing and other Neurological Testing
4. Well Child Visits.

   From birth up to the Member's 19th birthday with recommended visits scheduled as follows:
   a. 2 weeks; 1 month; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 24 months; 30 months.
   b. Ages 3 to 19: One visit per Benefit Period.
   c. Any other well child visits as recommended by the American Academy of Pediatrics.
   d. Immunizations as recommended by the Advisory Committee on Immunization Practices

   Well child visits shall include: a medical history, physical examination, developmental assessment, anticipatory guidance, necessary and appropriate immunizations and laboratory tests ordered at the time of the visit.
5. Obstetrical Services.
   a. Including, but not limited to, prenatal care, delivery and post-partum care. Coverage is also provided for the services of a duly licensed midwife. To be considered as In-Network, the midwife must have a collaborative relationship with a Participating Provider.
   b. Upon submission of a receipt to CDPHP as proof of payment, Members are eligible for reimbursement of 50% of the cost of childbirth classes up to a maximum of $30. Reimbursement is limited to one class per pregnancy.
6. Immunizations (see also Section VII).
7. Allergy Tests.
8. Allergy Injections.
9. Health Education and Nutritional Counseling.
10. Vision screenings done during a physical examination by the Member's Primary Care Physician.
11. Hearing Examinations ordered by a Participating Practitioner.
12. Surgical Procedures when performed in the office.
13. Chiropractic Services provided by a doctor of chiropractic licensed pursuant to Article 132 of the Education Law, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
14. Standard diagnostic testing for prostatic cancer, including, but not limited to, digital rectal examinations and prostate-specific antigen tests.
15. Medication management rendered by a Participating Practitioner psychiatrist.
16. Neuropsychological testing related to a medical Diagnosis and rendered by a Participating Practitioner. One hour of testing equals one unit of service. A Copayment applies for each unit of service.
17. Psychological testing related to a medical Diagnosis and rendered by a Participating Practitioner. One hour of testing equals one unit of service. A Copayment applies for each unit of service.
18. Chemotherapy Services.
19. Radiation Therapy.

**B. Inpatient Hospital Services.**

**Service**

**Inpatient Hospital Services include, but are not limited to:**

1. Semi-Private Room, Use of Operating, Recovery and Delivery Rooms, Anesthetic Materials, Laboratory Services, Dressings and Casts, Diagnostic Radiology and Imaging Services, Intravenous Injections and Infusion Therapy, Electroencephalograms, Electrocardiograms, Oxygen, Short-term Physical Therapy, Intensive/Cardiac Care, Central Supply Items, Chemotherapy and Radiation Therapy, Organ Scans, Blood and blood products, but only when there is a charge by the facility. Drugs, medications, biologicals and vaccines used in the Hospital.
2. Newborn Nursery Care.
   Inpatient Hospital care for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section.
3. Maternity care Coverage, including parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments, for Member and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and at least 96 hours following a caesarean section. The Member shall have the option to be discharged earlier than the 48 or 96 hours. In such case, one Home Health Care visit, which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of caesarean section), shall be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother's request, whichever is later. Any such Home Health Care visit shall not be subject to deductibles, Coinsurance or Copayments.
4. Inpatient Hospital Coverage for such period as is determined by the attending physician in consultation with the Member to be medically appropriate after a Member has undergone a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy Covered by the Contract.
5. Bariatric Surgery. We will provide Coverage for bariatric surgery only when such surgery is performed at a Hospital participating in CDPHP's designated bariatric surgery network. Information regarding the designated network may be obtained in the provider directory or by calling Member Services at (518) 641-3700 or 1-800-777-2273.

**C. Outpatient Hospital Services and Surgery and Freestanding Ambulatory Surgery Facility.** Only one Visit or Facility Copayment will be required per provider per day for the procedures listed below.

**Service**

**Outpatient Hospital and Freestanding Ambulatory Surgery Facility Services include, but are not limited to:**

1. Use of Operating and Recovery Rooms, Anesthetic Materials, Casts and Dressings, Intravenous Injections, Electroencephalograms, Electrocardiograms, Oxygen, Central Supply Items, Organ Scans, Preadmission Testing, Drugs, medications, biologicals and vaccines used in the Hospital, Blood and blood products, but only when there is a charge by the facility, other diagnostic services or treatments.
2. Bariatric Surgery. We will provide Coverage for bariatric surgery only when such surgery is performed at a Hospital participating in CDPHP's designated bariatric surgery network. Information regarding the designated network may be obtained in the provider directory or by calling Member Services at (518) 641-3700 or 1-800-777-2273.
3. Sleep Studies. Coverage for sleep studies only when such studies are performed in a Center participating in CDPHP's designated sleep center network. Information regarding the designated network may be obtained in the provider directory or by calling Member Services at (518) 641-3700 or 1-800-777-2273.

**D. Practitioners' Services when billed separately by the provider, not by the facility, when the Member is either in the Hospital, in a Skilled Nursing Facility or at a facility as an Outpatient.**

**Service**

1. Surgical Procedures.
2. Assistant Surgeon. A Participating Practitioner who assists another Participating Practitioner during the course of the operation, when the surgical procedure requires assistance.
3. General and Local Anesthesia Services.
4. Radiotherapy Treatment.
5. In-facility consultations and visits.
6. Surgical Pathology.
7. Obstetrical Services.
8. Initial Newborn Care.
9. Diagnostic Test Result Interpretation Services.

**E. Emergency Services.**

**Service**

1. Emergency Department Services.
   In and Out of the Service Area. No referral is required (see also Section V.B.). Copayment is waived only if the Member is admitted to the Hospital for observation or as an inpatient for the same Accidental Injury or illness within 24 hours.
2. Professional Ambulance Services.
   a. Pre-Hospital Emergency medical services, including prompt evaluation and treatment of an Emergency condition and/or non-airborne transportation to a Hospital. Services must be provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law. Evaluation and treatment services must be for an Emergency condition as defined in Section II of this Contract. Coverage for non-airborne Emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the

absence of such transportation to result in: 1) placing the health of the person afflicted with such a condition in serious jeopardy; 2) serious impairment to such person's bodily functions; 3) serious dysfunction of any bodily organ or part of such person; and/or 4) serious disfigurement of such person.
   b. Airborne Ambulance Services. Must be Medically Necessary and must be required as a result of an Emergency.
   c. Medically Necessary non-Emergency, non-airborne inter-facility transportation.
3. Participating Provider Urgent Care Facility Services. No referral is required.
**Non-participating Urgent Care Facility Services within CDPHP's Service Area are Not Covered. (see also Section V.D.).**

**F. Laboratory Services.**
**Service**
1. All laboratory services in the following settings: office based, outpatient hospital or freestanding facility. **A listing of preferred Participating laboratory Providers is available in the provider directory or will be provided upon request by calling Member Services at (518) 641-3700 or 1-800-777-2273.**

**G. Mental Health Care Services.**
**Service**
1. **Inpatient Services**
For diagnosis and treatment of Mental Health Care including all facility, diagnostic and physicians' charges. Inpatient services include care provided in a facility issued an operating certificate by the commissioner of mental health or in a facility operated by the office of mental health, or office-based Mental Health Care.
2. **Outpatient Services.**
Covered Health Services are Covered when provided by a participating licensed psychologist or psychiatrist, a licensed clinical social worker licensed mental health counselor or professional corporation or university faculty practice corporation. Coverage includes outpatient therapy, for diagnosis, evaluation and treatment of Mental Health Conditions. Outpatient services include care provided in a facility issued an operating certificate by the commissioner of mental health or in a facility operated by the office of mental health, or office-based Mental Health Care.
3. **Partial Hospitalization**
Partial hospitalization is Covered.

Members are encouraged to contact CDPHP Behavioral Access Center to verify eligibility prior to receiving Mental Health Care Services. Behavioral Health clinicians will verify eligibility and assist with referrals. Information regarding Mental Health Care services may be obtained by calling the Behavioral Health Access Unit at (518) 641-3600 or 1-888-320-9584.

**H. Substance Use Disorder and Dependency Treatment Services.**
**Service**
1. Inpatient Services. For Medically Necessary inpatient detoxification for Substance Use Disorder and dependency, including all facility, diagnostic and physicians' charges.
2. For inpatient rehabilitation services for the Diagnosis and treatment of Substance Use Disorder and/or dependency in a Hospital-based or freestanding chemical dependency facility. Treatment must be provided by trained professional personnel and may include individual or group counseling, activity therapy and diagnostic evaluations to determine the nature and extent of the illness.
3. Outpatient Services.—For Diagnosis and treatment of Substance Use Disorder and dependency.
4. Limitations.
   a. Services must be provided in: Participating Provider facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services; and, in other states, to those accredited by the J.C.A.H.O. as alcoholism or Substance Use Disorder treatment programs.
   b. Persons whose prime Diagnosis is alcohol abuse or alcoholism or Substance Use Disorder or substance dependence may be treated only in a facility certified to treat such Diagnosis.
   c. Care must be as a result of Substance Use Disorder or chemical dependence.
5. Treatment of associated health conditions will be Covered under basic Health Care Services of the Contract.

Members are encouraged to contact CDPHP Behavioral Access Center to verify eligibility prior to receiving Substance Use Disorder and Dependency Services. Behavioral Health clinicians will verify eligibility and assist with referrals. Information regarding Substance Use Disorder and Dependency services may be obtained by calling the Behavioral Health Access Unit (518) 641-3600 or 1-888-320-9584.

**I. Skilled Nursing Facility Services.**
**Service**
1. Up to 45 days per Benefit Period in a Semi-Private Room when ordered by a Member's Participating Practitioner and prior authorized by CDPHP's Medical Director or his/her designee. Copayment is waived when admission to the Skilled Nursing Facility occurs within three (3) days of discharge from the Hospital and as an alternative to hospitalization. Central supply items, drugs, medications, biologicals and vaccines are Covered when provided by a Skilled Nursing Facility.

**J. Home Health Care Services.**
**Service**
1. When ordered by a Participating Practitioner and approved in writing by CDPHP's Medical Director or his/her designee as an alternative to hospitalization or treatment in a Skilled Nursing Facility (as defined in 42 USC § 1395 et. seq.). The Covered services include: 1) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; 2) part-time or intermittent home health aide services which consist primarily of caring for the patient as

an adjunct to Skilled Nursing services; 3) physical, occupational or speech therapy if provided by the home health service or agency; 4) medical supplies, drugs and medications prescribed by a Participating Practitioner for administration by the Home Nurse; 5) laboratory services by or on behalf of the home health agency (see section IV.A & F for benefit limitations); and 6) home infusion therapy. Home Health Care Services are Covered to the extent such items would have been Covered or provided if the Member were hospitalized or confined in a Skilled Nursing Facility. A care plan must be established in writing and approved by the Participating Practitioner and CDPHP's Medical Director or his/her designee. CDPHP's Medical Director or his/her designee has the right to determine if Home Health Care is the most cost-effective approach to care. This determination can be made at any time during an episode of care. The medical necessity of Home Health Care Services is determined on a case-by-case basis.

**K. Non-Participating Practitioners and Providers' Services.**

**Service**

1. Subject to Section V. and VI., non-Participating Practitioners and Providers can provide Medically Necessary Covered Health Services. CDPHP must approve such referrals in advance and in writing, except in Emergency situations.

**Non-Participating Practitioners and Providers' Services are subject to the Copayment and/or Coinsurance according to section IV of this Contract.**

**L. Referral for Second Opinions.**

**Service**

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

**M. Durable Medical Equipment, Prosthetic Devices, Orthotics and Oxygen.**

**Service**

1. Durable Medical Equipment (DME)
   CDPHP will provide Coverage for rental, purchase, repair and/or replacement of DME (as defined in Section II of this Contract), subject to the following:
   a. The equipment has been ordered by a Participating Practitioner.
   b. Prior authorization by CDPHP's Medical Director or his/her designee is required when the cost of the item being purchased exceeds $500. All rented items require prior authorization.
   c. The equipment is provided by a Participating Provider vendor.
   d. Medically Necessary repair, adjustment or replacement of Covered equipment is also Covered. CDPHP reserves the right to determine whether replacement or repair is more appropriate. All repairs, adjustments or replacement of Covered equipment requires prior authorization by CDPHP's Medical Director or his/her designee.
   e. Coverage is provided for standard equipment only. Coverage for equipment with non-standard features is provided on a case-by-case basis, after review of medical necessity. If features or items deemed not Medically Necessary are included when the equipment is dispensed, CDPHP will provide Coverage for only those items or features deemed Medically Necessary. All requests for potentially non-Medically Necessary features or items will be subject to CDPHP's Utilization Review process, including all avenues of appeals.
   f. CDPHP reserves the right to determine whether rental or purchase is more appropriate.
   g. Supplies associated with DME are Covered when included in the rental fee or purchase price.
   h. Refer to Section VII for exceptions to Covered Benefits.
2. Prosthetic Devices
   Prosthetic devices are removable and not permanently implanted devices which replace all or part of a body organ, or replace all or part of a permanently nonfunctioning, absent or malfunctioning body part, including but not limited to, artificial limbs, eyes, and post-mastectomy breast prostheses. CDPHP will provide Coverage for the purchase of prosthetic devices subject to the following:
   a. The device must be ordered by a Participating Practitioner.
   b. Prior authorization by CDPHP's Medical Director or his/her designee is required when the cost of the device exceeds $500.
   c. The device is provided by a Participating Provider vendor.
   d. Medically Necessary repair, adjustment or replacement of the Covered device is also Covered. CDPHP reserves the right to determine whether replacement or repair is more appropriate. All repairs, adjustments or replacement of Covered equipment requires prior authorization by CDPHP's Medical Director or his/her designee.
   e. Coverage is provided for standard devices which restore basic function or appearance of the body part only. Coverage for devices with non-standard features is provided on a case-by-case basis, after review of medical necessity.
   f. Supplies associated with prosthetic devices are Covered when included in the purchase price.
   g. CDPHP provides benefits for the purchase of one Medically Necessary cranial prosthesis, wig or toupee per lifetime per Member for replacement of hair lost as a result of injury, disease or treatment of a disease. Coverage is limited to

a maximum amount of $400 per prosthesis, wig or toupee. This limitation is applied to the balance remaining after the Member's payment of the applicable Coinsurance as set forth in this Section. **Prior authorization requirement does not apply to services noted in section IV.M.2.g.**

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

3. Orthotic Devices
   Orthotic devices are rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. CDPHP will provide Coverage for the purchase of orthotic devices subject to the same criteria as set forth in paragraphs 2.a. through g. above. There is no Coverage for orthotic shoe inserts (see Section VII).
4. Oxygen
   Medically Necessary oxygen is Covered, subject to the same criteria as set forth in paragraphs 1.a. through h. above.

**N. Physical and Occupational Therapy Services. Office, Home or Outpatient based.**
**Service**

1. Includes Short-Term Therapy which can result in significant clinical improvement in a Member's condition. Coverage for physical and occupational therapy is limited to one course of 30 visits each over no longer than a 60 day period per Benefit Period (see Section VII).

**O. Speech Therapy Services. Office, Home or Outpatient based.**
**Service**

1. Includes Short-Term Therapy which can result in significant clinical improvement in a Member's condition. Coverage is limited to one course of 20 visits over no longer than a 60 day period per Benefit Period (see Section VII).

**P. Acute Short-Term Inpatient Rehabilitation Therapy Services.**
**Service**

1. Inpatient treatment in a Participating Provider rehabilitation unit or facility which can result in a significant clinical improvement in a Member's condition. Must be prior approved by CDPHP's Medical Director or his/her designee. Copayment is waived when admission to the rehabilitation unit or facility occurs within one day of Hospital discharge for the same injury or illness. Limited to a maximum stay of 60 days for each specific Diagnosis and related conditions for a continuous 12-month period.

**Q. Hospice Care.**
**Service**

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

**R. Diabetic Services.**
**Service**

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

   Diabetic equipment and supplies listed in R.a.ii. & R.b.ii above are Covered only when obtained from CDPHP's designated manufacturer of diabetic equipment or supplies. A designated diabetic equipment or supply manufacturer is a diabetic equipment or supply manufacturer which has an agreement with CDPHP to provide diabetic equipment or supplies for Covered Members through Participating Provider pharmacies.

   If a Member requires a certain item noted in R.a.ii. & R.b.ii that is not available from CDPHP's designated diabetic equipment or supply manufacturer, the Member, or the Member's provider, must submit a request for a medical exception by calling our Member Services department at (518) 641-3700 or 1-800-777-2273. CDPHP's Medical Director will make all medical exception determinations.
2. Medically Necessary self-management education and education relating to diet for persons diagnosed with diabetes provided by the physician or his/her staff, as part of an office visit for diabetes Diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician.
3. Routine diabetic eye examinations once every 12 months for Members that have a Diagnosis of diabetes. No referral is required if services are rendered by a Participating Practitioner (see also Section V.D.).

**S. Organ Transplant Services. Please see Section V.F. regarding limitations of coverage.** Services must be performed at a center in CDPHP's designated specialty network.

**Service**

1. Covered services include all Medically Necessary Hospital care at a transplant center and all Medically Necessary medical, surgical and other care otherwise Covered under this Contract.
2. Organ donation—CDPHP will cover the expense for donor hospitalization and related services directly related to the donation of an organ used in a Covered organ transplant (see Section VII).
3. Bone Marrow Searches—When the National Marrow Donor Program or the International Bone Marrow Transplant Registry or an equivalent registry or bank is utilized by a CDPHP-approved transplant center, CDPHP will provide Coverage for confirmatory typings for up to 10 individual potential donors. The Member's family may be included in these 10 allowed typings. This Coverage will be provided once per bone marrow transplant.

**T. Outpatient Dialysis Services.**

**Service**

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

1. In a Participating Provider Hospital-based or freestanding facility, dialysis treatment will be Covered if the facility and its programs are approved by the appropriate governmental authorities.
2. For home treatment, benefits will be provided for the reasonable rental cost of equipment, as determined by CDPHP, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by the Member's physician and approved by CDPHP's Medical Director or his/her designee. However, Covered benefits do not include any furniture, electrical or other fixtures, plumbing or professional assistance needed to perform the dialysis treatments at home.
3. For these home and facility-based benefits to be Covered, the treatments must be provided, supervised or arranged by the Member's Participating Practitioner.

**U. Breast Reconstruction Surgery.**

**Service**

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

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

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

**Please refer to these Contract Sections and the Schedule of Benefits regarding Copayment, and/or Coinsurance for each of the following sites of service: for physicians' office, see Section IV.A.; for inpatient Hospital, see Sections IV.B. and IV.D.; for outpatient Hospital and ambulatory surgery facility, see Sections IV.C. and IV.D.; for Prosthetic Devices, see Section IV.M.**

**V. Access to End of Life Care**

**Service**

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

**W. Infertility Services**

**Service**

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

c. See Section VII for exceptions to Covered benefits.
d. Coverage for fertility drug treatment is only provided under a Prescription Drug Rider. Such Coverage is subject to the terms, conditions, limitations and exclusions of any such Rider.
e. Members must be at least 21 years of age but no more than 44 years old to be Covered under this Section IV.W. for diagnostic and treatment procedures used in the diagnosis and treatment of infertility, including Prescription Drugs that may be Covered under any applicable Rider.

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

**X. Accidental Dental Services**

Dental Services for the treatment of Accidental dental Injuries to a sound natural tooth or dental treatment necessary due to congenital disease or anomaly. Coverage ends when the Member's Coverage under this Contract is terminated, even if the plan of treatment has not yet been completed. **(See section V.E. for prior authorization requirements.)**

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

# SECTION V—LIMITATIONS OF COVERAGE

**A. Referred Health Services**

1. Referral by a Primary Care Physician to a Participating Provider: In the event that Covered Health Services cannot be provided by the Member's Primary Care Physician, the Member shall be referred to another Participating Practitioner or Provider for Health Services. Such Health Services must be authorized in advance by the Primary Care Physician and be Covered by CDPHP, subject to the limitations and exclusions of the Contract. CDPHP will not pay for referral Health Services not authorized in advance by the Primary Care Physician except for necessary Emergency care as described in Section V.B. and other Medically Necessary services as described in Section V.D.
2. Referral by Participating Practitioner to a non-Participating Practitioner or Provider: In the event that Covered Health Services cannot be provided by a Participating Practitioner or Provider, the Member shall be referred to another physician or provider for Health Services. Such Health Services must be authorized in advance by the Primary Care Physician, and approved in writing by CDPHP's Medical Director or his/her designee prior to the services being rendered. The services provided will be subject to the limitations and exclusions of the Contract. CDPHP will not pay for any referral Health Services without prior approval by CDPHP's Medical Director or his/her designee and recommendation from the Primary Care Physician, except for necessary Emergency care as described in Section V.B. and other Medically Necessary services as described in Section V.D.
   a. When a Member has a medical condition that requires ongoing care from a specialist, a referral may be issued to that specialist for up to one year, provided that CDPHP, or the Member's Primary Care Physician in consultation with CDPHP's Medical Director or his/her designee and a specialist, if any, determines that such a referral is appropriate.
   b. A Member with a life-threatening condition or disease or a degenerative and disabling condition or disease, which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition. Such specialist shall be responsible for and capable of providing and coordinating the Member's primary and specialty care, provided that CDPHP, or the Member's Primary Care Physician in consultation with CDPHP's Medical Director or his/her designee and a specialist, if any, determines that the Member's care would most appropriately be coordinated by such a specialist. Such a referral shall be made pursuant to a treatment plan approved in advance by CDPHP, in consultation with the Member's Primary Care Physician, if appropriate, the specialist and the Member or Member's designee. Such specialist shall be permitted to treat the Member without a referral from the Primary Care Physician and may authorize such referrals, procedures, tests and other Health Services as the Primary Care Physician would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.
   c. A Member with a life-threatening condition or disease or a degenerative and disabling condition or disease, which requires specialized medical care over a prolonged period of time may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition, provided that CDPHP, or the Member's Primary Care Physician, or the specialist designated pursuant to paragraph V.A.3.b. above, in consultation with CDPHP's Medical Director or his/her designee, determines that the Member's care would most appropriately be provided by such a specialty care center. Such a referral shall be made pursuant to a treatment plan developed by the specialty care center and approved in advance by CDPHP, in consultation with the Member's Primary Care Physician, if appropriate, the specialist designated pursuant to paragraph V.A.3.b. above and the Member or Member's designee.

**B. Emergency Department Health Services**

1. Covered Worldwide: Emergency department Health Services are Covered in the event of an Emergency (as defined in Section II). Members are responsible for the Emergency Copayment for Emergency department Health Services, even if authorized by a Participating Practitioner or Provider, unless they are admitted to the Hospital for observation or as an inpatient within 24 hours of the Emergency department Health Services for the same illness or injury. Members should

contact their Primary Care Physician within 48 hours of receiving Emergency department Health Services, or as soon thereafter as is reasonably possible. Full details of the Emergency department Health Services provided shall be made available to CDPHP at its request. If the Member is hospitalized at a non-Participating Provider Hospital, he/she may be transferred to a Participating Provider Hospital, upon request of the Primary Care Physician and/or CDPHP's Medical Director, as soon as it is medically appropriate in the opinion of the attending physician. Emergency department Health Services are not subject to prior approval. Medically Necessary non-Emergency, non-airborne inter-facility transportation is subject to prior authorization.

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

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

**D. Covered Health Care Services That Do Not Require a Referral**

The following Covered Health Care Services do not require a referral as described in Section V.A.1. and V.A.2.:

1. Primary Care Office and Home Visits when the services are rendered by the Member's Primary Care Physician or designated Participating Ob/Gyn Practitioner as described in Section IV.A.;
2. Voluntary Family Planning when the services are rendered by the Member's Primary Care Physician or designated Participating Ob/Gyn Practitioner as described in Section IV.A.;
3. Obstetrical Services, including but not limited to, prenatal care, delivery and postpartum care when the services are rendered by the Member's Primary Care Physician or designated Participating Ob/Gyn Practitioner as described in Section IV.A.;
4. Routine Eye Examinations for Members that have a Diagnosis of diabetes when the services are rendered by a Participating Practitioner as described in Section IV.R;
5. Medically Necessary treatment and diagnostic testing for the sole purpose of inducing pregnancy when the services are rendered by the Member's Primary Care Physician or designated Participating Ob/Gyn Practitioner as described in Section IV.W.;
6. Participating Provider Urgent Care Facility Services as described in Section IV.E.3.
7. Emergency department Health Services as described in Sections IV.E.1. (see also Section V.B.).
8. Dental Services for the treatment of Accidental Injuries to a sound natural tooth or dental treatment necessary due to congenital defect or anomaly as described in Section IV.X, subject to all other terms and limitations of this Contract. **Prior authorization by CDPHP's Medical Director or his/her designee is still required**.
9. Inpatient and Outpatient Mental Health Care Services. Members must contact CDPHP by calling the Behavioral Health Access Unit (518) 641-3600 or 1-888-320-9584 prior to receiving services described in Section IV.G.
10. Inpatient and Outpatient Substance Use Disorder and Dependency Treatment Services. Members must contact CDPHP by calling the Behavioral Health Access Unit (518) 641-3600 or 1-888-320-9584 prior to receiving services described in Section IV.H.
11. If a Member's PCP has referred the Member to receive Health Services from a Participating Practitioner specialist practicing in one of the following specialties, the Participating Practitioner specialist may refer the Member to receive Physical and/or Occupational Therapy Health Services as described in Section IV.N., subject to all other terms and limitations in this Contract: neurology, pediatric neurology, neurosurgery, orthopedic surgery, physiatry, rheumatology, vascular surgery, pulmonary medicine and hand surgery. Participating Practitioner podiatry specialists are also included in this list for referrals for Physical Therapy only;
12. A Member's designated Participating Ob/Gyn Practitioner may refer the Member to receive Health Services from other Participating Providers which are specifically related to obstetrical and/or gynecological Diagnoses, subject to all other terms and limitations of this Contract.

**E. Case Management Program**

1. Case Management.

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

2. Alternative or Additional Benefits.

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

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

   The Member agrees that CDPHP may have access to and review on a concurrent basis any of the Member's Hospital and other medical records to evaluate alternative or additional care possibilities.

   Any proposal of alternative or additional care is limited to the facts and circumstances of the particular case reviewed and does not apply to any other case of that Member or to any other Member. Case Management is not a substitute for the advice and guidance of the Member's provider.

3. Termination of Program Participation.

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

**F. Organ Transplant Services.**

Pre-Certification Review of Organ Transplant Services

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

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

**G. Specialty Networks**

Certain services, including Organ Transplant and Bariatric Surgery Services, may only be obtained from a CDPHP designated specialty network provider. Information regarding the designated specialty network may be obtained in the provider directory or by calling Member Services at (518) 641-3700 or 1-800-777-2273.

**H. Pharmacy**

Only Medically Necessary Formulary Prescription Drugs are Covered.

Coverage is subject to the CDPHP Prescription Drug Formulary in place at the time the prescription is filled, including prior authorization, step therapy, and quantity limits. Members may contact the member services department at (518) 641-3700 or 1-800-777-2273 or may consult the CDPHP UBI website at www.cdphp.com to view the formulary and any coverage requirement.

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are Covered, subject to copayments that are no more than the copayment that would apply if provided as a medical benefit.

Notwithstanding anything to the contrary in this Contract or the Certificate, a limited refill of prescription eye drops prior to the last day of the dosage period is Covered, without regard to 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.

Members can contact our Member Service department at (518) 641-3700 or 1-800-777-2273 for instructions on using the mail order program. Any Medically Necessary Formulary Prescription Drug that is Covered and that can be obtained through the mail order program may also, at the Member's option, be obtained at a non-mail order pharmacy within CDPHP's designated pharmacy benefit manager's network if such non-mail order pharmacy has agreed to the same terms, conditions and reimbursement amounts as a mail order pharmacy. In such a case, the Member's Copayment shall be the same as if the Medically Necessary Formulary Prescription Drug were obtained through the mail order program.

Certain Prescription Drugs require prior authorization before they are filled. The following types of prescription drugs may require prior approval:

- Specialty pharmacy agents (see l. below)
- Injectables
- Recombinant DNA products
- Immune-modulating agents
- Monoclonal antibodies
- Enteral formulas/modified solid food products
- Weight loss agents
- Cosmetic agents used for non-cosmetic medical diagnoses
- Compounded prescriptions
- COX-2 inhibitors;
- All new to market Prescription Drugs or molecular entities until reviewed by CDPHP's P&T committee.
- Drugs that are recommended by P&T committee to be reviewed due to clinical effectiveness and/or safety profile or that have requirements based on the evaluation of other medical criteria.
- Prescription Drugs used off-label (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) other than those where the use is supported by certain reference-book citations. (These reference books, as amended, are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, then the drug is not be Covered.

When accessing an out of the Service Area pharmacy, it is the Member's responsibility to obtain prior approval for these drugs. Members may also contact the Member Services Department at (518) 641-3700 or 1-800-777-2273 or may consult the CDPHP website at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is Covered or if prior approval is required.

We may add prior authorization requirements on a drug when a therapeutically equivalent more cost effective Formulary drug becomes available or to promote safe utilization of a Formulary drug based on new clinical guidelines or information related to drug safety or effectiveness. These changes to the Formulary will be made following notice to affected Members.

When accessing an out of the Service Area pharmacy, it is the Member's responsibility to obtain prior approval for these drugs. Members may contact the Member services department at (518) 641-3700 or 1-800-777-2273 or may consult the CDPHP website at www.cdphp.com to review the list of the current drugs requiring prior authorization.

Specialty pharmacy agents listed on CDPHP's specialty drug list must be obtained at CDPHP's participating specialty vendor(s).

Specialty Drugs are prescription drugs which:

- Are approved to treat limited patient populations, indications or conditions
- Have market exclusivity to treat rare diseases
- Are administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical or inhalation.
- Require close monitoring by a physician or clinically trained individual
- Have unique/ limited distribution, special storage/handling /delivery requirements or special administration requirements
- Require additional patient support and education to maintain patient compliance and successful therapy of the drug
- May require laboratory or diagnostic testing for monitoring safety /effectiveness or may cause an increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home healthcare therapy

Members may contact the Member service department at (518) 641-3700 or 1-800-777-2273 or may consult the CDPHP website at www.cdphp.com to get a copy of the list of drugs that must be obtained through CDPHP specialty pharmacy vendor(s) and whether prior authorization is required. New additions to the specialty drug list will be made following notice to affected Members.

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

**A. Claim Form**

An itemized bill or a CDPHP Claim Form must be submitted to CDPHP at its office address set out on the face page of the Contract within 120 days after the date the Member incurs Medically Necessary Eligible Expenses for treatment of Accidental Injury or illness. All submissions of foreign bills and/or claim forms must include English translations and U.S. Dollar amount conversions where applicable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if such itemized bill or Claim Form is furnished as soon as reasonably possible. But in no event, except in the case of legal incapacity of the Member, shall such bill or claim be reimbursed if it is initially furnished to CDPHP later than one (1) year from the date on which services were provided or the course of treatment was completed.

**B. Payment of Claims**

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

**C. Legal Action**

No action at law or in equity shall be brought to recover under the Contract prior to the expiration of 120 days after the itemized bill or Claim Form and requested supporting information, if any, has been filed in accordance with the requirements of the Contract. Nor shall such action be brought after 12 months from the completion of Health Services for which payment is sought to be recovered.

# SECTION VII—EXCLUSIONS

1. Any Accidental Injury or sickness for which benefits, settlement(s), award(s) or damages are:
   a. received from a claim under:
      i. Workers' Compensation.
   b. received or payable from a claim under:
      i. Employer's Liability, or Occupational Disease Law; or
      ii. Medicare.
2. No benefits will be paid under the Contract for any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable. Any loss or portion thereof, for which benefits are provided under the Contract which are not recovered or recoverable from mandatory no-fault insurance, because such loss exceeds the maximum benefits provided under

such mandatory no-fault insurance, shall be paid without regard to the Coinsurance and/or Copayment provisions set forth in the Contract. Any loss, or portion thereof, for which benefits are provided under the Contract which is not received or recoverable from mandatory no-fault insurance because of a no-fault deductible shall be paid subject to the Coinsurance and/or Copayment provisions set forth in the Contract.

3. We will not provide benefits for the costs for which a Member is responsible for failure to keep an appointment with a Provider.
4. Prescription drugs and biologicals are excluded except for:
   a. Those received during a Covered inpatient admission to a Hospital, or Skilled Nursing Facility;
   b. Those received during the course of receiving Covered Home Health Care;
   c. Intravenous (IV) and intramuscular (IM) prescription drugs and biologicals when provided in conjunction with an approved Home Health Care nursing plan.
   d. Covered immunizations administered by a Participating Practitioner in his/her office and medical benefit formulary drugs obtained at the retail pharmacy;
   e. Covered allergy immunotherapy administered by a Participating Practitioner in his/her office;
   f. Diagnostic testing agents used during Covered diagnostic procedures;
   g. Intravenous (IV) and intramuscular (IM) prescription drugs or biologicals administered by a Participating Practitioner in his/her office. This Coverage does not apply to injectable fertility drugs, injectable or implantable contraceptive drugs or to intravenous (IV) and intramuscular (IM) prescription drugs or biologicals which are usually considered to be self-administered, but are being administered by the Participating Practitioner in his/her office or by a Home Health Care agency for reasons other than Medical Necessity. All determinations of medical necessity are subject to CDPHP's Utilization Review process including all avenues of appeals, up to and including external review.

   A CDPHP Prescription Drug Rider is required for Coverage of Prescription Drugs or biologicals that do not meet the above criteria.
5. Any Health Services rendered after the termination of Coverage (see Section III), except when a Member is determined to be eligible for benefits under the continuation of Coverage provisions of the Contract (see Section IX).
6. Durable Medical Equipment, prosthetics, orthotics and supplies, except as explicitly provided in Section IV.M. of this Contract. Duplicate equipment or devices (e.g., one for home and one for school). Repair or replacement of Durable Medical Equipment, prosthetic devices or orthotic devices due to loss, misuse or neglect. Environmental control items including, but not limited to, air conditioners, humidifiers, dehumidifiers and/or air purifiers. Repairs of equipment or devices that are subject to manufacturer warranty. Charges related to the shipping, handling and/or delivery of Covered equipment or devices. Equipment or devices prescribed solely for use during sports or for employment. Exercise equipment or devices used primarily for exercise. Computer assisted communication devices or electronic communication devices that are not implanted into the body. Medical supplies, except for supplies associated with Covered devices or equipment that are included in the rental fee or purchase price of the device or equipment.
7. Any dental care and treatment except for the treatment of a sound natural tooth needed as a result of an Accidental Injury or treatment needed due to a congenital disease or anomaly. Dental care and treatment needed as a result of an Accidental Injury is not Covered when it is provided more than 12 months from the date of the Accidental Injury, except when prior approved by CDPHP's Medical Director or his/her designee for Members whose future growth prohibits necessary treatment from being performed within 12 months of the Accidental Injury. The extension of the 12-month limitation should be approved during the initial treatment.
8. Coverage for temporomandibular joint disease (TMJ) is excluded when it is dental in nature.
9. Non-Medically Necessary cosmetic services, including plastic surgery, and elective treatment for aesthetic improvement of nondisabling physical defects or problems. This exclusion shall not apply to a cosmetic operation when it is Medically Necessary, or reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Covered Dependent child which results in a functional impairment. Reconstructive surgery shall not include surgery for scar repair/revision only, where no functional defect is present. Requests for potentially cosmetic procedures and services will be subject to CDPHP's Utilization Review process including all avenues of appeals. Nothing herein shall be interpreted to preclude the application of Insurance Law § 4303 regarding breast reconstruction surgery after a mastectomy.
10. Health Services which are not Medically Necessary for the Diagnosis and treatment of an Accidental Injury or illness or to maintain the Member's health. The Contract only covers Medically Necessary services.
11. Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies (hereinafter referred to as "Services") not proved to be safe and/or efficacious, or, because of a Member's condition, an efficacious procedure that will have no effect on the outcome of the Member's illness, injury or disease are not Covered. Benefits are limited to scientifically established Services that have been evaluated by recognized United States authorities or United States governmental agencies and have been found to have a demonstrable curative or significantly ameliorative effect for a particular illness, injury or disease. Services that are ineffective or are in the stage of being tested or researched with question(s) as to safety and/or efficacy are not Covered. Investigational or experimental procedures which are proven to be safe and efficacious for a particular illness, injury or disease which have received approval from the Federal Food and Drug Administration and/or the Agency for Healthcare Research and Quality may be Covered. CDPHP reserves the right to determine Coverage on a case-by-case basis. Nothing herein shall be interpreted to preclude the application of Insurance Law Section 4303 regarding cancer drugs. CDPHP's Medical Director or his/her designee shall have the authority to determine issues of Coverage raised under this Paragraph 11, and such determination is final as long as it is neither arbitrary nor capricious. CDPHP's Medical Director's or his/her designee's determination is subject to CDPHP's Claims and Appeals Procedures.

In general, CDPHP does not cover experimental or investigational treatments. If an external appeal agent overturns CDPHP's denial, CDPHP shall Cover the experimental or investigational treatment. If the external appeal agent approves Coverage for an experimental or investigational treatment that is part of a clinical trial, CDPHP will only Cover the costs of services required to provide treatment to the Member according to the design of the trial. CDPHP shall not be responsible for the cost of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Contract for non-experimental or non-investigational treatments.

12. Health Services received from a non-Participating Practitioner or Provider unless recommended by a Member's Primary Care Physician with CDPHP's prior written approval, except in an Emergency (see Section V).
13. Routine eye examinations or routine vision screenings other than those Covered under Sections IV. A & R.
14. The expense of purchasing, repairing or fitting eye glasses.
15. The expense of purchasing, repairing or fitting hearing aids.
16. Personal conveniences while an inpatient in a Hospital or other health care facility, such as private room, television, barber or beauty services, guest services and similar incidental services and supplies which are not Medically Necessary as part of the care for the Member.
17. Services performed by a Member's immediate family including spouse, brother, sister, parent or child.
18. Physical and mental examinations and immunizations required solely for employment or insurance, or for medical research, travel, school or camp.
19. Free care or care where no charge, in the absence of the Contract, would be made to the Member.
20. Benefits provided under Medicare or other governmental programs (except Medicaid and New York State Early Intervention programs), or services for which, in the absence of any Health Services plan or insurance plan, no charge would be made to the Member.
21. Any injury or illness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage for such injury or illness is provided through any governmental plan or program.
22. Travel and transportation expenses even though prescribed by a physician, except as provided in Section IV of the Contract.
23. Inpatient and outpatient Hospital services, unless arranged in advance by a Participating Practitioner or Medically Necessary because of an Emergency.
24. Hospital clinic services unless arranged in advance by a Participating Practitioner and prior approved by CDPHP's Medical Director or his/her designee.
25. Benefits otherwise provided in the Contract which CDPHP is unable to provide because of any law or regulation of the federal, state or local government, or any action taken by any agency of the federal, state or local government in reliance on said law or regulation.
26. Long-term therapies including Physical Therapy, speech therapy, occupational therapy, long-term physical rehabilitation and/or long term spinal manipulation.
27. Therapies to address developmental delays or educational deficiencies.
28. Non-Emergency Health Services rendered outside the Service Area where the Member should have reasonably foreseen the need for such services prior to leaving the Service Area, unless CDPHP approves such services in writing, in advance.
29. Any expense as a result of a Member's failure to vacate his/her Hospital bed beyond the discharge time or date established by the Hospital, Participating Practitioner and CDPHP.
30. Orthotic shoe inserts and routine foot care. This includes services or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
31. Non-Medically Necessary custodial care or rest cures and services rendered for the convenience of a Member or provider. Care is considered custodial when it is primarily for the purpose of helping the Member with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. All requests for potentially custodial procedures and services will be subject to CDPHP's Utilization Review process including all avenues of appeals.
32. Court-ordered treatment for Mental Health and/or Substance Abuse Conditions and/or Health Services, unless such treatment and/or services are rendered by a Participating Practitioner or Provider and are determined to be Medically Necessary.
33. Services required by an employer.
34. Dietary supplements or replacements. Not included in the exclusion is total parenteral nutrition.
35. Intensive weight loss programs.
36. Storage of blood or blood products. This does not apply to autologous (one's own blood) blood donations. Benefits for transfusion services, including storage, for autologous donations of blood and blood components are available when associated with a scheduled, Covered Surgical Procedure.
37. Infertility services and assisted reproductive services, including the following: in vitro fertilization; ZIFT (Zygote Intrafallopian Transfer); GIFT (Gamete Intrafallopian Transfer); and all expenses related to reversal of voluntary sterilization, including vasectomy and tubal ligation, sex change procedures, cloning or medical or surgical procedures that are deemed experimental in accordance with the standards and guidelines establi1shed and adopted by the American Society for Reproductive Medicine.
38. Benefits or services prescribed by a physician but not expressly Covered by the Contract.
39. CDPHP will not provide Coverage for non-Medically Necessary transplants of artificial or animal organs. All requests for potentially experimental or investigative procedures and services will be subject to CDPHP's Utilization Review process including all avenues of appeals. CDPHP will not provide coverage for travel, food and lodging for transplant recipient or donor, or costs relating to searches or screenings beyond that provided for in Section IV.S. paragraph 3 for donors of organs to be transplanted.
40. Laboratory services are not Covered unless provided in accordance with Section IV.

41. Treatment provided in a governmental Hospital, or other institution which is owned, operated or maintained by the Veterans Administration, the federal government, a state government, or any local government, unless the Hospital is a Participating Provider. However, CDPHP will pay for care Covered under the Contract in a governmental Hospital, if because of serious injury or sudden illness, a Member is taken to such a Hospital for Emergency care because it is close to the place where he/she was injured or became ill. In this type of Emergency situation, CDPHP will continue to make payments only for as long as Emergency care, in CDPHP's sole judgement, is necessary and until it is possible for the Member to be transferred to a Participating Provider Hospital.
42. The Member is financially liable for services received from a non-Participating Practitioner or Provider (except with prior written approval from CDPHP), or for any non-Covered procedure, treatment or service.
43. Private duty nursing.

# SECTION VIII—CONVERSION PRIVILEGE

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

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

The Member shall not be eligible to convert to the Non-Group Contract if the Member is actually covered under another group or individual plan or the Member is eligible for comparable group coverage through an employer.

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

# SECTION IX—EXTENSION AND CONTINUATION OF COVERAGE

**A. Extension of Coverage**

1. CDPHP's Medical Director will make all determinations regarding whether a Member is Totally Disabled. If a Member is considered to be Totally Disabled while Covered by the Contract, Coverage for that specific disabling condition will be continued, upon termination of Coverage, during a continuous period of Total Disability.
   a. Coverage shall continue for the lesser of:
      i. The period for which the Member, based on the decision from CDPHP's Medical Director, is determined to be Totally Disabled;
      ii. The extent of the available benefits; or
      iii. 12 months from the date that the Member's Coverage is terminated; or
   b. If Coverage is terminated due to termination of active employment, Coverage for the disabling condition will be extended for 12 months or until the Member is covered by other insurance or Group health plan which provides coverage for the disabling condition, whichever occurs first.
2. The Coverage of an unmarried Dependent child will be continued past the maximum age limitation for such Coverage if the child is:
   a. Incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the New York Mental Hygiene Law, or physical handicap and who became so incapable prior to attainment of age 26, unless eligibility for Dependent status has been extended by a Rider, in which case the age limit of the Rider shall apply; and
   b. Chiefly dependent upon the Subscriber for support and maintenance.

To be eligible for extended Coverage, proof of the child's incapacity and dependency must be furnished to CDPHP within 31 days of the date of the child's 26th birthday, or within 31 days of the date on which Coverage would otherwise terminate.

**B. Continuation of Coverage**

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

   Continuation of Coverage under New York law shall terminate on the date 36 months after the date of the Subscriber's termination from employment. In the case of an eligible Dependent of the Subscriber, continuation of Coverage shall terminate on a date 36 months after the date such person's benefits under the Contract would otherwise have terminated by reason of:
   a. The death of the Subscriber;
   b. The divorce or legal separation of the Subscriber from his or her spouse;
   c. The Subscriber becoming entitled to benefits under Medicare; or
   d. A Dependent child ceasing to be a Dependent child under the requirements of the Contract.

   In the case of a Subscriber who is determined, pursuant to Medicare law, to be disabled at the time of termination of employment or at any time during the first 60 days of continuation of Coverage, then the continuation of Coverage shall terminate 36 months after the date the Subscriber's Coverage under the Contract would otherwise have terminated.

   Continuation of Coverage under the Contract shall terminate if the Member fails to make timely payment of the required premium. Monthly premium payments must be made in advance to the Group. Any questions regarding continuation rights should be directed to the Group or CDPHP.
3. Continuation of Coverage will end at the first of the following to occur:
   a. Termination under COBRA or New York continuation rules; or
   b. The end of the period for which premium payments were made (where premiums are not paid on time); or
   c. The date on which the Contract is terminated.
4. The Conversion privilege described in Section VIII is available when any period of continuation of benefits under this section ends.

**C. Young Adult Option: Coverage for Unmarried Young Adults through Age 29**

**1. Eligibility**

Dependents: To be eligible to enroll as a Dependent under this provision, an individual must be:
   a. A child of an eligible Subscriber
   b. Age 29 or younger
   c. Unmarried
   d. Not insured by or eligible for coverage through the dependent's own employer-sponsored group policy or contract
   e. Live, work or reside in New York State or CDPHP's Service Area.
   f. Not covered under Medicare.

2. Conditions of Coverage
   a. Dependents who have reached the maximum age of eligibility outlined in Section III of this contract are eligible to independently purchase coverage under the Group policy through the age of 29
   b. Dependents do not need to live with the Subscriber, be financially dependent upon the Subscriber, or be a full-time student.
   c. There is a separate premium for the young adult option, which the young adult or the young adult's parent must pay.
   d. Children of the Dependent are not eligible for coverage under this provision.
   e. The Subscriber or the Dependent may elect this option. The Subscriber or Dependent, not the employer, is responsible for the premium, which the Subscriber or Dependent should remit payment to the group policy holder.

**3. Enrollment.**

The Dependent or Subscriber has the following opportunities to elect this option.
   a. Loss of Coverage.
      When the Dependent would otherwise lose coverage due to age. A Dependent may elect this option within 60 days of the date that he or she would otherwise lose eligibility for coverage under the Subscriber's policy due to age. Coverage is retroactive to the date that the dependent would have otherwise lost coverage due to reaching a specified age.
   b. Special Enrollment Period.
      A Dependent may elect this option within 60 days of newly meeting the eligibility requirements if each of the following conditions is met:

i. The Dependent was covered under a group health plan or had health insurance coverage at the time Coverage was previously offered to the Dependent.
ii. The Dependent's coverage:
- Was under a COBRA continuation provision and the coverage under such provision was exhausted; or
- Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce or annulment, death of a spouse, termination of employment, termination of the other plan or contract, or reduction in the number of hours of employment).

iii. Coverage will be effective within 30 days of when the group policy holder receives written notice of the election and payment of the first premium.

c. During the Group's Open Enrollment Period
Dependents may elect this option during the Group's annual open enrollment period.

**4. Termination of Coverage**
Coverage through the young adult option ends when one of the following occurs:
a. the dependent voluntarily terminates coverage pursuant to the terms of the policy or contract;
b. the dependent's parent is no longer covered under the group policy;
c. the dependent no longer meets the eligibility requirements for this option;
d. the required premium is not paid in full within the 30-day grace period; or
e. the group policy is terminated and not replaced.

**D. Supplementary Conversion and Continuation Rights.**
Under State law, a member of a reserve component of the armed forces of the United States, including the National Guard, who either: (a) voluntarily or involuntarily enters upon active duty (other than for the purpose of determining his or her physical fitness and other than for training), or (b) has his or her active duty voluntarily or involuntarily extended during a period when the president is authorized to order units of the ready reserve or members of a reserve component to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and (c) serves no more than four years of active duty, has the right to conversion or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty.

# SECTION X—COORDINATION OF BENEFITS ("COB")

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

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

   If the specific terms of a court decree or separation agreement state that one of the parents is responsible for the health care expenses of a child, any entity obligated to pay or to provide the benefits of the plan of such parent that has actual

knowledge of those terms, shall have benefits determined first. This paragraph shall not apply with respect to any claim determination period of a plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

5. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as the employee's Dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee or Member longer are determined before those of the plan which covered that person for the shorter period of time.

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

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

E. The order of primary responsibility stated in Section XI.B. above may not apply when the Member is Covered under this Contract and Medicare. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), as amended:
   1. Medicare coverage is primary when the Member is age 65 or older and:
      a. When the Member's CDPHP Coverage is under a Group Benefit Plan offered by an employer with fewer than 20 employees (unless the employer is part of a multi-employer plan where at least one of the employers has 20 or more employees); or
      b. When the Member's CDPHP coverage is due to a reason other than the Subscriber's current employment status (i.e. the Subscriber is Covered as a retiree);
   2. Medicare coverage is also primary when the Member's Medicare coverage is by virtue of the Member being disabled and:
      a. When the Member's CDPHP Coverage is under a Group Benefit Plan offered by an employer with less than 100 employees (or an employee organization when none of the employers employs at least 100 employees); or
      b. When the Member's CDPHP Coverage is due to a reason other than the Subscriber's current employment status (i.e. the Subscriber is Covered as a retiree); or
   3. When a Member's Medicare coverage is also by virtue of the Member having end stage renal disease, Coverage under this Contract is primary for 30 months beginning the first month in which the Member becomes entitled to or eligible for Medicare benefits by virtue of the Member having end stage renal disease. After the end of such 30-month period, Medicare coverage is primary.

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

# SECTION XI—RIGHT OF RECOVERY

If a Member receives benefits under the Contract and he/she also receives money from a third party judgment or settlement in payment for the same benefits, then CDPHP UBI may only recover from such Member the reasonable value of the benefits provided pursuant to a statutory right of recovery, such as under Medicaid, no fault insurance, and workers' compensation. Recovery by CDPHP UBI shall be limited to amounts received by the Member for Hospital, medical and surgical services.

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

# SECTION XII—RELATIONSHIP BETWEEN PARTIES

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

The relationship between a Participating Practitioner and any Member is that of practitioner and patient. The Participating Practitioner is solely responsible for the Health Services provided to any Member. CDPHP is not liable for any act, omission or

other conduct of any practitioner or provider in furnishing professional, ambulatory, Hospital or any other services to Members. Nor is any Participating Practitioner or Provider liable for the acts of any other practitioner or provider based solely upon his/her or its association with CDPHP.

# SECTION XIII—GENERAL PROVISIONS

**A. Entire Contract.**

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

**B. Time Limit on Certain Defense.**

No statement, except a fraudulent misstatement, shall be used to void the Contract after it has been in force for a period of two (2) years.

**C. Alteration.**

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

**D. Consent to Release of Medical Information.**

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

**E. Forms.**

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

**F. Records.**

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

**G. Notice.**

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

**H. Covered Benefits.**

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

**I. Certificate.**

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

**J. Severability.**

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

**K. Workers' Compensation Not Affected.**

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

**L. Pronouns.**

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

**M. Conformity with Statutes.**

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

**N. Events Beyond Our Control.**

In the event of circumstances not reasonably within the control of CDPHP (such as complete or partial destruction of health care facilities, war, riot, civil insurrection or similar causes), CDPHP shall not be responsible to arrange for the provision of Health Services.

**O. Waiver.**

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

**P. Interpretation.**

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

**Q. Construction**

CDPHP shall have final authority to construe and interpret all terms in the Contact, including any terms that may appear unclear or uncertain. Any construction of the provisions of the Contract adopted by CDPHP in good faith shall be binding upon the Group, Subscribers and Members.

**R. Anti-Vesting**

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

# SCHEDULE OF BENEFITS

## Capital District Physicians' Health Plan
## HMO

**Glossary of Terms**

- **Lifetime Maximum.** the total Allowed Amount for Covered Benefits that CDPHP will pay per Member per Lifetime pursuant to the Group Contract
- **Annual Maximum.** the total Allowed Amount for Covered Benefits that CDPHP will pay per Member per Benefit Period pursuant to the Group Contract

**Member Cost-Share**

| **Benefit** | |
|---|---|
| Lifetime Maximum–All Covered Benefits | Unlimited Per Covered Member |
| Lifetime Maximum–Durable Medical Equipment, Orthotics, Prosthetics & Oxygen | Unlimited Per Covered Member |
| Annual Maximum–All Covered Benefits | Unlimited Per Covered Member |
| Primary Care Office Visit Copayment | **$10** Copayment per office visit |
| Specialty Care Office Visit | **$10** Copayment per office visit |
| **Office or Outpatient Hospital Based Health Services**<br>**Only one visit Copayment will be required per provider per day** | |
| **Covered Services** | |
| Primary Care Office and Home Visits | **$10** Copayment |
| One primary care routine physical exam per benefit period | Covered in Full |
| One routine gynecological physical exam per benefit period | Covered in Full |
| All other gynecological physical exams. | **$10** Copayment |
| Diagnostic Services:<br>Radiology and imaging, including: X-rays, Ultrasounds, Diagnostic Nuclear Medicine, MRIs and CT Scans<br>(Copayment waived if services performed by preferred radiology network provider. A listing of preferred radiology providers is available in the provider directory or will be provided upon request by calling Member Services at (518) 641-3700 or 1-800-777-2273.) | **$10** Copayment |
| Mammograms | Covered in Full |
| Bone Mineral Density Measurements and Tests | **$10** Copayment |
| Cervical Cytology Screenings | Covered in Full |
| Well Child Visits | Covered in Full |
| Obstetrical Services | Covered in Full |
| Immunizations | Covered in Full |
| Allergy Tests | **$10** Copayment |
| Allergy Injections | Covered in Full |
| Nutritional Counseling | **$10** Copayment |
| Surgical Procedures when performed in the office | **$10** Copayment |
| Chiropractic Services | **$10** Copayment |
| Standard diagnostic testing for prostatic cancer | Covered in Full |
| Medication management rendered by a Participating Practitioner psychiatrist | Refer to Outpatient Mental Health Care Services Copayment |

| **Office or Outpatient Hospital Based Health Services**<br>**Only one visit Copayment will be required per provider per day** | |
|---|---|
| **Covered Services** | |
| Neuropsychological testing related to a medical Diagnosis and rendered by a Participating Practitioner | **$10** Copayment |
| Chemotherapy | **$10** Copayment |
| Radiation Therapy | **$10** Copayment |
| Urgent Care Services | **$20** Copayment |
| Second Surgical/Medical Opinions | **$10** Copayment |
| Physical Therapy | **$10** Copayment |
| Occupational Therapy | **$10** Copayment |
| Speech Therapy | **$10** Copayment |
| All other routine well adult visits | Refer to Primary Care Office Visit Copayment |
| All other routine well chile visits | Refer to Primary Care Office Visit Copayment |
| **Laboratory Services** | |
| Office Based Laboratory Services (Copayment waived if services performed by a designated participating laboratory provider. A listing of designated participating laboratory providers is available in the provider directory or will be provided upon request by calling Member Services at (518) 641-3700 or 1-800-777-2273.) | **$10** Copayment |
| Outpatient Hospital Based Laboratory Services (Copayment waived if services performed by a designated participating laboratory provider. A listing of designated participating laboratory providers is available in the provider directory or will be provided upon request by calling Member Services at (518) 641-3700 or 1-800-777-2273.) | **$10** Copayment |
| Freestanding Facility Based Laboratory Services (Copayment waived if services performed by a designated participating laboratory provider. A listing of designated participating laboratory providers is available in the provider directory or will be provided upon request by calling Member Services at (518) 641-3700 or 1-800-777-2273.) | **$10** Copayment |
| **Inpatient Hospital Based Health Services**<br>**In-Network–Individual Coverage:** the Subscriber Covered under this plan is responsible for the applicable Copayment per Continuous Confinement. This is limited to two Copayments per Benefit Period, after which hospitalization will be Covered in full.<br>**Family Coverage:** the Subscriber and each Dependent must meet the applicable Copayment per Continuous Confinement. This is limited to three Copayments per family per Benefit Period, after which hospitalization will be Covered in full. | |
| Inpatient Hospital Service | **$0** Copayment |
| Newborn Nursery Care | Covered in Full |
| Maternity Care | Covered in Full |
| Bariatric Surgery | **$0** Copayment |
| Skilled Nursing Facility Services | **$0** Copayment |
| Organ Transplant Services | **$0** Copayment |
| Practitioners Services when billed separately by the provider, not by the facility. | Covered in Full |
| Acute Short-Term Inpatient Rehabilitation Services | **$0** Copayment |
| **Outpatient Hospital Surgery and Freestanding Ambulatory Surgery Facility Services** | |
| Surgery & Use of Operating and Recovery Rooms | **$10** Copayment |
| Bariatric Surgery | **$10** Copayment |

| **Emergency Services** | |
|---|---|
| **Covered Services** | |
| Emergency Department Services | **$50** Copayment |
| Professional Ambulance Services | **$50** Copayment |
| Medically Necessary non-Emergency, non-airborne inter-facility transportation | Covered in Full |
| **Substance Use Disorder and Dependency Treatment Services** | |
| Outpatient Substance Use Disorder Services | **$10** Copayment |
| Inpatient Substance Use Disorder Detoxification Services | **$0** Copayment |
| Inpatient Substance Use Disorder Rehabilitation Services | **$0** Copayment |
| **Mental Health Care Services** | |
| Outpatient Services | **$10** Copayment |
| Inpatient Facility Services | **$0** Copayment |
| Partial Hospitalization | **$0** Copayment |
| **Medical Services** | |
| Home Health Care Services | Covered in Full |
| Durable Medical Equipment, Prosthetic, Orthotic Devices and Oxygen | **20%** Coinsurance |
| Hospice Care | Covered in Full |
| Outpatient Dialysis Services | **$10** Copayment |
| Access to End of Life Care | Covered in Full |
| **Diabetic Services** | |
| Diabetic Durable Medical Equipment | **$10** Copayment |
| Diabetic Drugs & Supplies: 30-day Supply | **$10** Copayment |
| Diabetic Drugs & Supplies–Mail Order | 30-day supply: **$10** Copayment<br>31-60 day supply: Two-Month Copayment<br>61-90 day supply: **$25** Copayment |
| Medically Necessary Self-Management Education | **$10** Copayment |
| Diabetic Eye Exam | **$10** Copayment |

# LARGE GROUP HMO AUTISM SPECTRUM DISORDER AMENDMENT

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

**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 CDPHP 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, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

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

- 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, CDPHP Covers the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if the Member is unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the Member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; CDPHP will only Cover devices that generally are not useful to a person in the absence of a communication impairment. CDPHP UBI will not Cover items, such as, but not limited to, laptops, desktop, or tablet computers. CDPHP Covers 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. CDPHP will determine whether the device should be purchased or rented.

  Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in the Member's physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered; however, CDPHP will Cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the Member's current functional level. CDPHP will not provide Coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. CDPHP Covers counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. CDPHP will provide such Coverage when provided by a licensed Provider. CDPHP Covers applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "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.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- Psychiatric and Psychological Care. CDPHP Covers direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- 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.

- 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 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.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the 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.

The Member is responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Contract for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to Specialist office visits will apply to assistive communication devices Covered under this paragraph.

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 Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

# RIDER FOR PRESCRIPTION DRUGS

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

| PRESCRIPTION DRUG COPAYMENTS | |
|---|---|
| Tier 1 Drugs | $5 Copayment per 30-day supply |
| Tier 2 Drugs | $20 Copayment per 30-day supply |
| Tier 3 Drugs | $35 Copayment per 30-day supply |

| MAIL ORDER<br>Subject to all limitations noted above, CDPHP-approved maintenance drugs for chronic conditions are available by mail order, except specialty agents, subject to the following Copayments: | |
|---|---|
| **Tier 1 Drugs** | |
| 30-day supply | $5 Copayment |
| 31-60 day supply | $10 Copayment |
| 61-90 day supply | $12.50 Copayment |
| **Tier 2 Drugs** | |
| 30-day supply | $20 Copayment |
| 31-60 day supply | $40 Copayment |
| 61-90 day supply | $50 Copayment |
| **Tier 3 Drugs** | |
| 30-day supply | $35 Copayment |
| 31-60 day supply | $70 Copayment |
| 61-90 day supply | $87.50 Copayment |
| The Member must show his/her ID Card and pay the dispensing pharmacy within CDPHP's designated pharmacy benefit manager's network the appropriate cost-share for each supply or refill of a Covered Prescription Drug. These amounts paid are not applicable to the Deductible or Coinsurance Maximum set forth in the Contract unless otherwise indicated. | |
| Members can contact our Member Service department at **(518) 641-3700 or 1-800-777-2273** for instructions on using the mail order program. | |

**SECTION II**
**DEFINITIONS**

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

**63.** **Tier 1 Drug**: A Prescription Drug that is included on CDPHP's Tier 1 Drug list. Tier 1 Drugs are selected for their effectiveness and utilization.

**64.** **Tier 2 Drug**: A Prescription Drug that is included on CDPHP's Tier 2 Drug list. Tier 2 Drugs are selected for their effectiveness and utilization.

**65.** **Tier 3 Drug:** A Covered Prescription Drug that is not on Tier 1 or Tier 2.

Members may contact the Member Services Department at **(518) 641-3700 or 1-800-777-2273** or may consult the CDPHP website at www.cdphp.com for a list of Covered Drugs and tier status.

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**Y. Prescription Drugs**

**Service**

1. Coverage for Prescription Drugs is subject to the following conditions:
   a. The prescription for the drug must be filled at a pharmacy within CDPHP's designated pharmacy benefit manager's network. Members may contact CDPHP's Member Services Department at **(518) 641-3700 or 1-800-777-2273** to determine if a pharmacy is within CDPHP's designated pharmacy benefit manager's network.
   b. Only Medically Necessary doses of Prescription Drugs are Covered.
   c. The maximum supply shall be limited to a 30-day supply, the amount prescribed, or the commonly accepted unit of use, whichever is less. The mail order benefit as noted above is the only exception to the 30-day supply limitation.
   d. The pharmacy must have a valid prescription for the drug written by a duly licensed health care provider at the time the Member receives the initial supply of a Covered Prescription Drug.
   e. Unless otherwise indicated by the prescribing provider, all Prescription Drugs will be filled with Tier 1 Prescription Drugs.
   f. Refills of Prescription Drugs shall be dispensed only as ordered by a duly licensed health care provider subject to the maximum supply limitations in paragraph IV.Y.1.c.
   g. In the event that no pharmacy within CDPHP's designated pharmacy benefit manager's network is able to provide the ordered Prescription Drug within a reasonable time, the Member may go to any other pharmacy in the Service Area that can fill the prescription. Upon receipt from the Member of a completed Claim Form or documentation deemed acceptable by CDPHP, CDPHP will reimburse the Member the difference between the Allowed Amount and the Copayment for such Prescription Drug, set out in "e" above.
   h. Injectable fertility drugs, injectable or implantable contraceptive drugs prescribed for non-contraceptive purposes, and intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered are Covered and must be prior approved by CDPHP's Medical Director or his/her designee. These items will be subject to the Copayment set out in "e" above. This includes intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered, but are being administered by the practitioner in his/her office for reasons other than medical necessity.
   i. Compounded medications are considered Tier 3 Prescription Drugs and must contain at least one FDA approved ingredient with an FDA approved or labeled use.
   j. Coverage is subject to the CDPHP Prescription Drug Formulary that is in effect on the date the prescription is filled. The following types of prescription drugs may require prior approval:
      - Specialty pharmacy agents (see l. below)
      - Injectables
      - Recombinant DNA products
      - Immune-modulating agents
      - Monoclonal antibodies
      - Enteral formulas/modified solid food products
      - Weight loss agents
      - Cosmetic agents used for non-cosmetic medical diagnoses
      - Compounded prescriptions
      - COX-2 inhibitors;
      - All new to market Prescription Drugs or molecular entities until reviewed by CDPHP's P&T committee.

- Drugs that are recommended by P&T committee to be reviewed due to clinical effectiveness and/or safety profile or that have requirements based on the evaluation of other medical criteria.
- Prescription Drugs used off-label (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) other than those where the use is supported by certain reference-book citations. (These reference books, as amended, are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, then the drug is not be Covered.

It is the Member's responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in the Member being responsible for the total cost of the drug. Members may also contact the Member Services Department at **(518) 641-3700 or 1-800 777-2273** or may consult the CDPHP website at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is Covered or if prior approval is required.

k. Specialty pharmacy agents must be obtained at CDPHP's participating specialty vendor(s.) Up to a 30-day supply is available. Specialty Drugs may be administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical or inhalation. CDPHP designates drugs as specialty through evaluation of the following characteristics: frequency of dosage adjustments, frequency of severity of adverse effects and side-effects, requirements for storage, handling and/or administration, therapeutic range, frequency of required laboratory or diagnostic testing for monitoring safety or effectiveness, increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home healthcare therapy, requirements for significant on-going one-to-one patient support and education to maintain patient compliance and to ensure the proper storage/handling/administration of the drug, severity of compliance risk, need for work-life adjustments by patients or caregivers to adhere or successfully implement the therapy and limited distribution of the drug. Prescription drugs listed on CDPHP's specialty drug list which require prior authorization as part of a clinical management program must be obtained at CDPHP's participating specialty pharmacy vendor(s), for up to a 30-day supply, upon prior approval from CDPHP. Specialty pharmacy agents used to treat the following diseases: asthma, growth hormone, hepatitis C, HIV, infertility, MS, psoriasis, pulmonary hypertension, osteo/rheumatoid arthritis, oral oncology drugs, implantable drugs used for endometriosis, prostate cancer, breast cancer, cyctic fibrosis, Gaucher disease, congenital alpha-1 inhibitor deficiency, Fabry disease, Mucopolysaccharidosis-1, anemia, neutropenia, thrombocytopenia and complications of chronic granulomatous disease or osteopetrosis must be obtained at the specialty vendor(s). Members may also contact the Member Service Department at **(518) 641-3700 or 1-800-777-2273** or may consult the CDPHP website at www.cdphp.com to determine whether a prescription drug is listed on CDPHP's specialty drug list meets this requirement.

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

m. Certain Covered Prescription Drugs that due to either quality and/or clinical consideration or use for lifestyle may be limited in coverage based on medical necessity. All requests for these prescription drugs will be subject to CDPHP's utilization review process including all avenues of appeals.

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

o. Prescription Drugs and devices that are approved by the federal Food and Drug Administration for purposes of bone mineral density measurements and testing are Covered.

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

q. Over-the-counter drugs that are included on CDPHP's formulary are subject to the Tier 1 Copayment in Section IV.Y.e. above.

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

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

2. The following items are excluded from Coverage:

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

b. A Prescription Drug will not be covered if there is an over-the-counter Prescription Drug with same active ingredients.

c. Vitamins, except those requiring a prescription, even if they are ordered by a Participating Practitioner.

d. Experimental and/or investigative drugs, unless recommended by an external appeal agent. All determinations regarding requests for potentially experimental and/or investigative drugs will be subject to Section VII, Exclusions, including all avenues of appeals.

e. Devices of any type (except those devices specifically Covered in paragraph 1.o. or 1.p. above or under any additional Rider), such as, but not limited to, syringes, therapeutic devices, appliances and hypodermic needles, even if they must be ordered by the provider.

f. Refills will not be Covered if they are needed because a Member loses or misuses his/her supply of Prescription Drugs, even if such a refill is ordered by the provider.

g. Prescription refills in excess of the number specified by the provider or dispensed more than one year from the date of the provider's original order.

h. Any drug, medicine or medication used for cosmetic purposes. All determinations regarding requests for potentially cosmetic drugs, medicine or medication used for cosmetic purposes will be subject to Section VII, Exclusions, including all avenues of appeals.

i. Drugs used in connection with a non-Covered service or a non-Covered benefit.

j. Drugs or pharmacological therapies recognized by CDPHP as being not Covered per Section IV.Y.1.k. above.

k. Elective nutritional supplements.

l. A separate Rider is required for the Coverage of contraceptive drugs and/or devices prescribed for contraceptive purposes.

m. This Rider is not intended to duplicate the benefits provided under your Contract. Prescription Drugs provided under your Contract are not Covered under this Rider.

**SECTION VII**
**EXCLUSIONS**

4. This exclusion is deleted from the Contract.

# RIDER FOR CONTRACEPTIVE DRUGS AND DEVICES

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

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**Y. Prescription Drugs**
**Service**

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

## PRESCRIPTION DRUG AMENDMENT

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

**MAIL ORDER PROGRAM**

Subject to all limitations noted above, CDPHP-approved maintenance drugs for chronic conditions are available through CDPHP's mail order program, except specialty agents, subject to the following Copayments/Coinsurance:

**SECTION II**
**DEFINITIONS**

**61**. **Formulary:** The list of Prescription Drugs that are Covered under your benefit.

**62**. **Tier 1 Drug**: A Formulary Prescription Drug or over-the-counter drug that is included on CDPHP's Tier 1 Drug list. Tier 1 Drugs are selected for their effectiveness and utilization.

**63.** **Tier 2 Drug**: A Formulary Prescription Drug that is included on CDPHP's Tier 2 Drug list. Tier 2 Drugs are selected for their effectiveness and utilization.

**64.** **Tier 3 Drug:** A Covered Formulary Prescription Drug that is on CDPHP's Tier 3 drug list.

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**Y. Prescription Drugs**
**Service**

1. Coverage for Prescription Drugs is subject to the following conditions:
   - b. Only Medically Necessary doses of Formulary Prescription Drugs are Covered.
   - e. Unless otherwise indicated by the prescribing provider, all Formulary Prescription Drugs will be filled with generic Prescription Drugs.
   - f. Refills of Formulary Prescription Drugs shall be dispensed only as ordered by a duly licensed health care provider subject to the maximum supply limitations in paragraph IV.Y.1.c.
   - g. In the event that no pharmacy within CDPHP's designated pharmacy benefit manager's network is able to provide the ordered Formulary Prescription Drug within a reasonable time, the Member may go to any other pharmacy that can fill the prescription. Upon receipt from the Member of a completed Claim Form or documentation deemed acceptable by CDPHP, CDPHP will reimburse the Member the difference between the Allowed Amount and the Copayment for such Formulary Prescription Drug, set out in "e" above. Claims will be subject to all Formulary utilization rules, including prior authorization, step therapy and quantity limits.
   - h. Formulary injectable fertility drugs, injectable or implantable contraceptive drugs prescribed for non-contraceptive purposes, and intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered are Covered and must be prior approved by CDPHP's Medical Director or his/her designee. These items will be subject to the Copayment/Coinsurance set in the Schedule of Benefits. This includes intravenous (IV) and intramuscular (IM) Prescription Drugs or biologicals which are usually considered to be self-administered, but are being administered by the practitioner in his/her office for reasons other than medical necessity.
   - i. Compounded medications are considered Tier 3 Formulary Prescription Drugs and must contain at least one FDA approved Formulary Prescription Drug with an FDA approved or labeled use. Compounded medications require prior authorization.
   - j. Coverage is subject to the CDPHP Prescription Drug Formulary including prior

authorization, step therapy, and quantity limits that are ~~is~~ in effect on the date the prescription is filled. Members may contact the member services department at (518) 641-3140 or 1-877-269-2134 or may consult the CDPHP website at www.cdphp.com to view the formulary and any coverage requirements.

Certain Prescription Drugs require prior authorization before they are filled. These drugs are identified on the Formulary. We may add prior authorization requirements on a drug when a therapeutically equivalent more cost effective Formulary Prescription Drug becomes available or to promote safe utilization of a Formulary Prescription Drug based on new clinical guidelines or information related to drug safety or effectiveness.

It is the Member's responsibility to obtain prior approval for these drugs. Failure to obtain prior approval will result in the Member being responsible for the total cost of the drug. Members may also contact the Member services department at (518) 641-3140 or 1-877-269-2134 or may consult the CDPHP website at www.cdphp.com to review the list of the current drugs requiring prior authorization.

Certain Prescription Drugs require step therapy before they are filled. These drugs are identified on the Formulary. Step therapy means that one type of Covered Formulary Prescription Drug, such as a generic drug or a cost-effective alternative to a prescribed drug, must be used before another. We may add step therapy requirements on a drug when a therapeutically equivalent more cost effective Formulary Prescription Drug becomes available or to promote safe utilization of a Formulary Prescription Drug based on new clinical guidelines or information related to drug safety or effectiveness. Members may also contact the Member services department at (518) 641-3140 or 1-877-269-2134 or may consult the CDPHP website at www.cdphp.com to review the list of the current drugs requiring step therapy.

All new to market Formulary Prescription Drugs or molecular entities require prior authorization until reviewed by CDPHP's P&T committee;

k. Specialty pharmacy agents listed on CDPHP's specialty drug list must be obtained at CDPHP's participating specialty vendor(s) for up to a 30-day supply. Specialty vendor(s) often mail the specialty drug to the Member, but these drugs are not part of the mail-order programs as noted in the Schedule of Benefits.

Specialty Drugs are Formulary Prescription Drugs which:

- Are approved to treat limited patient populations, indications or conditions
- Have market exclusivity to treat rare diseases
- Are administered by various methods, including, but not limited to: injection, infusion, implant, oral, transdermal, topical or inhalation.
- Require close monitoring by a physician or clinically trained individual
- Have unique/ limited distribution, special storage/handling /delivery requirements or special administration requirements
- Require additional patient support and education to maintain patient compliance and successful therapy of the drug
- May require laboratory or diagnostic testing for monitoring safety /effectiveness or may cause an increased utilization of medical services such as increased practitioner office visits, practitioner infusion services or home healthcare therapy

Members may contact the Member service department at (518) 641-3140 or 1-877-269 2134 or may consult the CDPHP website at www.cdphp.com to get a copy of the list of drugs that must be obtained through CDPHP specialty pharmacy vendor(s).

l. Formulary Prescription Drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Coverage for such modified food products per Calendar Year for any Member shall not exceed $2,500.

m. Certain Covered Formulary Prescription Drugs that due to either quality and/or clinical consideration or use for lifestyle may be limited in coverage based on medical necessity. All requests for these prescription drugs will be subject to CDPHP's utilization review process including all avenues of appeals.

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

o. Formulary Prescription Drugs and devices that are approved by the federal Food and Drug Administration for purposes of bone mineral density measurements and testing are Covered.

q. Over-the-counter drugs that are included on CDPHP's Formulary are subject to the Tier 1 Copayment/Coinsurance in the Schedule of Benefits.

r. Claim Form: A CDPHP Claim Form must be submitted to CDPHP at its office address set out on the face page of the Contract within 120 days after the date the Member incurs Medically Necessary Eligible Expenses for Formulary Prescription Drugs. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if such Claim Form is furnished as soon as reasonably possible. But in no event, except in the case of legal incapacity of the Member, shall such claim be considered for reimbursement if it is initially furnished to CDPHP later than one (1) year from the date on which services were provided.

2. The following items are excluded from Coverage:

b. A Formulary Prescription Drug will not be covered if there is an over-the-counter drug with the same active ingredients.

m. This Rider is not intended to duplicate the benefits provided under your Contract. Formulary Prescription Drugs provided under your Contract are not Covered under this Rider.

n. Any drug not listed on the Formulary.

**SECTION VII**
**EXCLUSIONS**

4. This exclusion is deleted from the Contract.

## RIDER FOR CONTRACEPTIVE DRUGS AND DEVICES

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

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**Y. Prescription Drugs**

**Service**

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

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

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

**Schedule of Benefits**
**Capital District Physicians' Health Plan, Inc.**
**HMO**

| **Medical Services** | |
|---|---|
| **Covered Services** | |
| Durable Medical Equipment, Prosthetic, Orthotic Devices and Oxygen | 20% Coinsurance |

# RIDER TO MODIFY COVERED HEALTH SERVICES

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**I. Skilled Nursing Facility Services.**
**Service**

1. Up to 90 days per Benefit Period in a Semi-Private Room when ordered by a Member's Participating Practitioner and prior authorized by CDPHP's Medical Director or his/her designee. Copayment is waived when admission to the Skilled Nursing Facility occurs within three (3) days of discharge from the Hospital and as an alternative to hospitalization. Central supply items, drugs, medications, biologicals and vaccines are Covered when provided by a Skilled Nursing Facility.

**N. Physical and Occupational Therapy Services.**
**Service**

1. Includes short-term therapy which can result in significant clinical improvement in a Member's condition. Possibility of significant clinical improvement is solely determined by CDPHP and must occur within 120 days or less from the date of the first treatment. Coverage for physical and occupational therapy each are limited to one course of 120 days or less of Short-Term Therapy for each specific Diagnosis and related condition per Benefit Period (see Section VII).

**O. Speech Therapy Services.**
**Service**

1. Includes short-term therapy which can result in significant clinical improvement in a Member's condition. Possibility of significant clinical improvement must occur within 60 days or less from the date of the first treatment and is solely determined by CDPHP. Speech therapy Coverage is limited to one course of 60 days or less of Short-Term Therapy for each specific Diagnosis and related condition per Benefit Period (see Section VII).

**P. Acute Short-Term Inpatient Rehabilitation Therapy Services.**
**Service**

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

**Schedule of Benefits**
**Capital District Physicians' Health Plan, Inc.**
**HMO**

| | |
|---|---|
| Outpatient Hospital Surgery Facility Services | Office Visit Copayment |
| Freestanding Facility Based Laboratory Services | Covered in Full |
| Freestanding Ambulatory Surgery Facility Services. | Covered in Full |
| Skilled Nursing Facility Services | Covered in Full |
| Acute Short-Term Inpatient Rehabilitation Services | Covered in Full |

# RIDER TO ADD ROUTINE EYE EXAM AND VISION HARDWARE BENEFITS

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

**SECTION IV**
**COVERED HEALTH CARE SERVICES**

**A. Office Based Health Services**

**Service**

21. Routine eye examinations are available every 24 months, commencing on the Group Effective Date (see Section VII). No referral is required if services are rendered by a Participating Practitioner (see also Section V.D.). Routine eye examinations are subject to copayment listed in Section IV.A.

**Y. Optical Dispensing Benefits**

| Service | | Maximum Benefit Paid by CDPHP |
|---|---|---|
| 1. Covered items include the following: | | |
| a. | Frames & Lenses | **$75** |
| b. | Contact Lenses | **$75** |

2. Limitations.
   a. One pair of frames and lenses or contact lenses, but not both, may be received once every 24 months, commencing on the Group Effective Date.
   b. Lenses and frames must be ordered and received during the term of the Member's contract.
3. Exclusions.
   a. Any supplies used with eyeglasses or contact lenses.
   b. Prescription or non-prescription sunglasses.
   c. Safety glasses required for the performance of a job.
   d. Replacement of lenses, frames, and/or contact lenses which are lost, stolen, or broken.

**SECTION V**
**LIMITATIONS OF COVERAGE**

**D. Covered Health Care Services That Do Not Require a Referral**

The following Covered Health Care Services do not require a referral as described in Section V.A.1. and V.A.2.:

4. Routine eye examinations when the services are rendered by a Participating Practitioner as described in Sections IV.A. and IV.R.

**SECTION VII**
**EXCLUSIONS**

13. Routine eye examinations or routine vision screenings other than those Covered under Sections IV.A. and IV.R.

## RIDER TO REMOVE CONTRACEPTIVE COVERAGE

**Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under Your Contract, benefits for the items and services are hereby added to Your Contract:

A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").

The preventive services referenced above shall be covered in full when received from Participating Providers. The preventive services referenced above are only covered when provided by Participating Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at www.cdphp.com, or will be mailed to you upon request. You may request the list by calling the Member Service number on your identification card.

**Coverage Exclusions:** Contraceptive methods and counseling - All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are excluded from Coverage.

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.**
**500 Patroon Creek Blvd. • Albany, NY 12206-1057**

The terms of the Contract to which these Riders are attached shall remain in full force and effect, except as amended by these Riders.

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

**By:** _____

**John D. Bennett, MD, FACC**
**President and CEO**