HEALTH INSURANCE PLAN OF NEW YORK
HIP PRIME
CERTIFICATE OF COVERAGE

Please carefully read this entire HIP PRIME℠ (HIP) Health Maintenance Organization ("HMO") Certificate of Coverage ("Certificate"), including the attached Schedule of Benefits which contains specific information regarding benefits. These documents, and any attached Amendments and/or Riders and the HIP Member Handbook, describe Members' rights and obligations and those of HIP.

Under this Certificate, the Member's Group has chosen to engage HIP to make arrangements through which Medical Services and Hospital Services will be delivered in accordance with the terms and conditions of this Certificate and in reliance upon the statements made in the application for coverage. HIP has agreed with the Group to provide the benefits set forth in this Certificate, as may be amended from time to time by HIP. This is not a contract between the Member and HIP.

* This Certificate is based on an HMO Contract between Health Insurance Plan of New York and the Member's Group explaining the benefits covered hereunder.

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SECTION ONE

INTRODUCTION AND DEFINITIONS

This Certificate provides Members with coverage for certain health care services through an HMO. In an HMO, care must be Medically Necessary and Appropriate and must be referred by the Primary Care Physician ("PCP") and/or approved in advance by the HIP Member Advocacy Program, or its designee. Also, coverage will only be provided for care that is rendered by Participating Providers, except in the case of Emergency Medical Conditions or when, in our sole judgment, the care required is not available from a Participating Provider.

Because care must be provided, arranged or referred by the PCP, coverage is not available, and HIP will not pay for any services unless each Member covered under this Certificate has selected a PCP. Each Member covered under this Certificate must select a PCP from the HIP Participating Provider Directory.

Coverage under this Certificate is made as a result of the Subscriber's relationship to a Group such as an employer, union or association. Group Subscribers must meet HIP's eligibility rules as well as eligibility rules established by the Group. The Group acts on behalf of the Subscriber by remitting premium for this coverage. HIP will provide the benefits described in this Certificate.

Definitions. As used in this Certificate, the following words and phrases shall apply:

Birthing Center means any Participating Provider in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated low-risk pregnancy. A Birthing Center is not an ambulatory surgical center or Hospital.

Calendar Year means the period beginning at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next anniversary of that date.

Copayment means the fee charged to a Member at the time of service for certain Covered Services and Benefits in the amount set forth on the attached Schedule of Benefits.

Covered Services means the Medical Services and Hospital Services that are described in this Certificate.

Contract Year means a period of twelve (12) consecutive months as determined from the Effective Date of the Group Contract and this Certificate.

Dependent means the individuals in the Subscriber's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section and are enrolled under this Certificate.

Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

Services received for the treatment of an Emergency Medical Condition as defined above are not subject to prior approval. As such, no claim for valid emergency services will be denied because approval in advance was not obtained.

Full Time Student means a Member who is enrolled and attends an accredited institution of higher learning in accordance with the institution's minimum requirements for Full Time Student status. A student is considered full time during normally scheduled school vacations if he or she is registered to return to that or a similar institution at the end of the vacation.

Group means the association, corporation, labor union or other group contracting with HIP for Medical Services and Hospital Services described herein.

HIP means the Health Insurance Plan of New York, an HMO organized under applicable state laws.

HIP Member Advocacy Program means the unit of the HIP Care Management Department that has specially trained managed care service representatives and nurses to assist Members and Providers in obtaining Covered Services and complying with the prior approval requirements under this Certificate.

Hospice Care Program means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of Terminally Ill persons and their families; a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness; and a program for persons who have a Terminal Illness and for the families of those persons. Hospice Care services may only be provided by a hospice organization certified pursuant to Article Forty of the NYS Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospice Care Services means any services provided by: (a) a Participating Hospital, (b) a Participating Skilled Nursing Facility, (c) a Participating Home Health Care agency, (d) a Participating Hospice facility or (e) any other Participating licensed facility or agency under a Hospice Care Program.

Hospital means an acute general care facility operated pursuant to law which: 1) is primarily engaged in providing, for compensation from its patients diagnostic and therapeutic services by, or under the supervision of, a staff of physicians; 2) has 24 hour nursing services by registered professional nurses; and 3) is not a federal hospital other than a Veterans Administration hospital or a Department of Defense hospital; or 4) is not, other than incidentally, a place for rest, custodial care for the aged, or a nursing home, convalescent home or similar institution. An alcoholism or drug treatment facility, a psychiatric hospital, a rehabilitative hospital and an outpatient surgical facility are considered Hospitals provided each is licensed and operated with the laws of the jurisdiction in which it is located.

Hospital Services (except as limited or excluded under this Certificate) means services for registered bed patients or outpatients which are customarily provided by acute care hospitals and which are approved in advance by the HIP Member Advocacy Program. Hospital Services shall also include approved Hospital inpatient and outpatient services from a Hospital accredited by the American Osteopathic Association when such services are available in the Service Area.

Identification Card means the card that HIP issues to Members upon enrollment. When a Member arrives at a Participating Provider to receive Covered Services, the Member must show the provider his or her Identification Card to verify coverage by HIP.

Medical Services (except as limited or excluded under this Certificate) means those professional services of Physicians or Other Participating Health Professionals, including medical, surgical, psychiatric, diagnostic, therapeutic and preventive services approved by HIP.

Medically Necessary and Appropriate means those health care services or supplies, determined solely by HIP or its designee, that are necessary to prevent, diagnose, correct or cure conditions in the Member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the Member's capacity for normal activity or threaten some significant disability and that could not have been omitted under generally accepted medical standards or provided in a less intensive setting.

Member means any Subscriber or any Dependent.

Mental Illness means any disorder that impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin.

Non-Participating Provider means any Hospital, Physician or other health care provider that is not under contract, directly or indirectly, with HIP to provide services to Members or approved in advance by the HIP Member Advocacy Program to provide Covered Services to Members.

Other Participating Health Care Facility means any facility other than a Participating Hospital or Hospice Care Facility that is operated by HIP or has an agreement, directly or indirectly with HIP, to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed, skilled nursing facilities and rehabilitation hospitals.

Other Participating Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement, directly or indirectly with HIP, to render services to Members.

Participating Hospital means a Hospital which has an agreement, directly or indirectly with HIP, to provide Hospital Services to Members.

Participating Physician means a Primary Care Physician or other Physician who has an agreement, directly or indirectly with HIP, to provide Medical Services to Members.

Participating Provider means any Hospital, physician, pharmacy, Other Participating Health Professional, and Other Participating Health Care Facility that has an agreement, directly or indirectly, with HIP to provide services to Members.

Physician means an individual who is (a) licensed to practice medicine and/or surgery; or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Certificate by the laws of the jurisdiction where treatment is given; or is a partnership or professional association or corporation of such individuals in (a) or (b) above.

Primary Care Physician means a Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement, directly or indirectly with HIP, provides basic health services to and arranges specialized services for those Members who select him or her as their Primary Care Physician.

Pre-existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by a duly licensed medical professional or received within the six (6) month period ending on the enrollment date. Except that, pregnancy is not considered a Pre-existing Condition and genetic information may not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such genetic information.

Rehabilitative Therapy (except as limited or excluded under this Certificate) means treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy, cardiac therapy and occupational therapy.

Rider means an addendum to the Certificate as well as the contract between the Group and HIP which increases or decreases the benefits available herein.

Service Area means the geographic area, within which HIP is licensed to operate, which is presently Bronx, Kings, New York, Queens, Staten Island, Nassau, Suffolk, Westchester, Orange and Rockland counties.

Subscriber means an individual who meets eligibility requirements under the Group Contract and is covered under this Certificate.

Terminal Illness means an illness, of a Member, which has been diagnosed by a Physician and for which the Member has a prognosis of six (6) months or less.

Totally Disabled means, in the case of an adult Member, an injury or illness pursuant to which the adult Member is completely unable to perform the usual tasks required of his or her employment at the time of the onset of the injury or illness, and which renders such person incapable of performing tasks of any employment for which the Member would otherwise be fit by reason of age, education, or training. A Dependent child is considered Totally Disabled when, by reason of injury or illness, he or she is completely unable to engage in the normal activities of a person of the same sex and age.

Usual and Customary Charges means the lesser of the usual charge made by Physicians or other health care providers for a given service or supply, or the charge HIP determines to be the prevailing charge by Physicians or other health care providers in the geographical area where it is furnished.

SECTION TWO

ELIGIBILITY

Who is Covered. The Subscriber to whom this Certificate has been issued, as a result of his or her relationship with the Group, is covered hereunder, and if such person has selected family coverage, the following family members of the Subscriber are also covered:

A. The Subscriber's wife or husband, unless the marriage has been terminated by divorce or annulment.

B. Unmarried children of the Subscriber who are under the age limit shown on the attached Schedule of Benefits. Coverage of each child will end on the last day of the month in which the child becomes that limit, or the date of marriage, whichever occurs first.

C. Unmarried children of the Subscriber who are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined under applicable state law, or because of physical handicap. The condition must have occurred before the child reached the age indicated on the Schedule of Benefits. The child's disability must be certified by a Physician. In addition, HIP may require proof that the child remains eligible for coverage under this Certificate. Failure to submit the required proof may result in

termination of coverage under this Certificate. In any event, coverage will terminate on the date it is determined that the child is no longer incapable of self-support.

D. Unmarried children under the age limit shown on the attached Schedule of Benefits, enrolled as a Full Time Student at an accredited institution of higher learning. The students' principal residence, when not away at school, must be the same as their parents'. Coverage of such Full Time Student will terminate as of the end of the month in which the child no longer meets all of these conditions, or the date of marriage, whichever occurs first. HIP may require proof that the child remains eligible for coverage under this Certificate as a Full Time Student. Failure to submit the required proof may result in termination of coverage under this Certificate.

In order to obtain Coverage under this Certificate, HIP must receive notification from the Group within thirty (30) days after the addition of a new family member. If family coverage was not originally selected, the Group must notify HIP within thirty (30) days after the event in order to obtain coverage for the new family member. See below for eligibility rules concerning newborns and adoptions.

Other Covered Children. If family coverage has been selected, the following other children, in addition to the natural children of the Subscriber and spouse, are also covered if the child meets the above criteria for covered children:

- A legally adopted child.

- A child for whom the Subscriber is the legal guardian and who is chiefly dependent upon the Subscriber for support and meets the criteria for dependent eligibility established under Section 152 of the United States Internal Revenue Code.

- A child for whom the Subscriber is the proposed adoptive parent and who is dependent upon the Subscriber during the waiting period prior to the adoption becoming final.

Newborn Child. If family or parent-child coverage has been selected, newborn children will be covered from the date of birth. If individual or husband-wife coverage has been selected, HIP must be notified in writing within thirty (30) days of the birth of a newborn child in order to receive coverage from the moment of birth for injury or sickness including congenital defects, birth abnormalities and premature birth. If the Subscriber decides to switch to the appropriate coverage category but the Group fails to notify HIP or HIP does not receive the applicable premium within thirty (30) days of the birth, the coverage will not become effective until the first day of the month following the date the request is received and the applicable premium is paid.

Adopted Newborns. If family coverage has been selected, HIP will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

- The Subscriber takes physical custody of the infant as soon as the infant is released from the hospital after birth; and

- The Subscriber files an adoption petition pursuant to applicable state law within thirty (30) days after the infant's birth.

Notwithstanding the above, HIP will not cover delivery and subsequent routine nursery care of adopted newborns if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed or one of the natural parents of the child revokes consent to the adoption. If HIP pays benefits to cover an adopted newborn and the adoption is revoked, or one of the natural parents revokes consent, HIP shall be entitled to recover from the Subscriber any sums paid by us for care of the adopted newborn.

Pre-Existing Conditions. Subject to the conditions set forth herein and if indicated on the attached Schedule of Benefits, Contracts issued to Groups which cover less than fifty (50) Subscribers shall exclude coverage of Pre-Existing Conditions for a period of no more than twelve (12) months.

Pre-Existing Condition exclusions shall not apply to new Dependents who enroll or are otherwise covered under Creditable Coverage within thirty (30) days of:

- The date of birth, adoption or placement for adoption.

Provided that the break in coverage between the prior plan and coverage under this plan does not exceed does not exceed sixty-three (63) days, exclusive of any waiting periods.

Creditable Coverage. Creditable Coverage means benefits or coverage which is continuous to a date within sixty-three (63) days of enrollment under this Certificate, exclusive of any waiting period, and which was provided under any group health plan, public or private, health insurance coverage, Part A or Part B of Title XVIII of the Social Security Act, Chapter 55 of Title 10, United States Code, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits health risk pool, a health plan offered under Chapter 89 of Title 5, United States Code, a health benefit plan under Section 5(e) of the Peace Corps Act, Title XIX of the Social Security Act (Medicaid) or a public health benefit plan. Accident or disability income policies, policies for supplements to liability insurance, liability insurance, workers' compensation, auto medical payments, credit-only insurance, coverage provide by on-site medical clinics, and others as may defined by the Department of Insurance are not considered Creditable Coverage.

If offered separately, the following are not considered Creditable Coverage:

- Limited scope dental or vision benefits.
- Long term care, nursing home care, home health care, community-based care, or any combination.
- Coverage for Medicare Supplement insurance.

If offered independently and as non-coordinated benefits, the following are also not considered Creditable Coverage:

- Coverage for specified disease or illness-only insurance.
- Hospital indemnity or other fixed indemnity insurance, unless the plan's coverage amounts are greater than those set forth in applicable regulations.

Covered Persons With Creditable Coverage. A Subscriber or Dependent who had Creditable Coverage continuously to a date sixty-three (63) days before the person's enrollment date will be given credit without regard to benefits for the partial satisfaction of a Pre-existing Condition limitation waiting period if that person was subject to a Pre-existing Condition limitation under the previous coverage and had not satisfied a twelve (12) month Pre-existing Condition waiting period.

A Member whose Creditable Coverage was in effect for 12 months or longer, will not be subject to a Pre-existing Condition limitation waiting period if he or she was covered under Creditable Coverage continually to date sixty-three (63) days before the enrollment date under this Certificate.

Credit Towards Waiting Period. The amount of time which a Member was covered under any other health insurance policy or HMO contract or employer sponsored health benefit plan will be counted towards the waiting period described above if there was no break in coverage greater than 63 days between the termination of the prior coverage and the date of enrollment under this Certificate. HIP reserves the right to request a certificate of prior coverage from a Member to establish the amount of time, termination date and benefit coverage of the prior coverage.

SECTION THREE

ROLE OF THE PRIMARY CARE PHYSICIAN

By enrolling in this HIP Plan, Members choose to have services and benefits under this Certificate provided, or arranged by a PCP. The PCP maintains the physician-patient relationship with Members who select him or her as their PCP. The PCP is responsible for providing and/or coordinating Medical Services and Hospital Services for the Member. Members may self-refer to Participating Providers for only those services described in Section Five of this Certificate under the paragraph entitled "Direct Access Medical Services." All other services must be referred or arranged by the Member's PCP and/or approved in advance by the HIP Member Advocacy Program. Please refer to the HIP Member Handbook for details about the HIP Member Advocacy Program.

At time of enrollment, each Subscriber must select a PCP for himself or herself and each Dependent. The Subscriber may select a different PCP for himself or herself and each Dependent. The Member's PCP is responsible for determining the treatment most appropriate for the Member's health care needs.

A Member who wishes to change his or her PCP, must contact HIP and follow its instructions. HIP reserves the right to limit the number of such changes.

SECTION FOUR

HOSPITAL SERVICES

Subject to the attached Schedule of Benefits, inpatient care in a Participating Hospital for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis is covered when approved in advance by the HIP Member Advocacy Program. Such services shall include, but are not limited to, semi-private room and board; care and services in an intensive care unit or special care unit; drugs, medications, anesthesia, biologicals, vaccines, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities, including cytoscopic rooms and equipment; supplies and use of equipment in connection with oxygen; organ transplants; the administration of blood and blood products; x-rays, laboratory, pathological examinations, intravenous preparations and visualizing dyes for care in the Hospital and other diagnostic services; preadmission testing; inhalation therapy, physiotherapy, radiation therapy, physical, speech and occupational therapy; and such other services customarily provided in acute care Hospital unless otherwise excluded in this Certificate.

Preadmission Testing. Preadmission testing performed in a Participating Hospital, as planned preliminary to ambulatory surgery or an inpatient admission of a Member for surgery in the same hospital, is covered, provided that:

- Tests are necessary for and consistent with diagnosis and treatment of the condition for which surgery is to be performed;
- Reservations for a Hospital bed and for an operating room shall have been made prior to the performance of the tests;
- Surgery actually takes place within seven (7) days of such pre-surgical tests; and
- The Member is physically present at the Hospital for the tests.

Organ Transplants. Coverage is provided for organ transplants that are determined by HIP, in its sole discretion, to be non-Experimental or non-Investigational.
Covered transplants include but are not limited to: kidney, corneal, liver, heart and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. All covered transplants must be prescribed by the Member's PCP or other Participating

Physician, and approved in advance by the HIP Member Advocacy Program. Additionally, all transplants must be performed at Hospitals that HIP has specifically approved and designated to perform these procedures.

Coverage will be provided for Hospital and medical expenses of the Member-recipient. Coverage is not provided for the Hospital and medical expenses of a non-Member acting as a donor for a Member if the non-Member's expenses will be covered under another health plan or program. Coverage is not provided for travel expenses, lodging, meals or other accommodations for members receiving transplant services including the organ recipient, donors, guests or family members.

Breast Reconstruction Benefits. Members are entitled to reconstructive breast surgery following a mastectomy. Covered services include:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy including lymph edemas.

Coverage is limited only to Members diagnosed with breast cancer. These benefits do not apply to elective cosmetic surgery, which is not covered under this Certificate.

Maternity Care Services. Covered maternity care services include hospital, surgical and medical and midwifery care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy in a Hospital or licensed Birthing Center as well as parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Such maternity care services include inpatient Hospital coverage for mother and routine nursery care for the newborn for at least forty-eight (48) hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six (96) hours following a caesarean section.

The Member has the option to be discharged earlier than the time periods stated above. In such case, the inpatient Hospital coverage will include one (1) home care visit, in addition to any Home Health Care benefits otherwise available under this Certificate. The home care visit may be requested and will be provided at any time within twenty-four (24) hours after discharge of the mother from the Hospital or after the mother's request, whichever is later and is not subject to any Copayments otherwise required under this Certificate.

Short Term Speech, Occupational, Physical and Respiratory Therapy Services. Coverage will be provided for short-term speech, occupational, physical and respiratory

services when a Member is admitted to a Hospital for treatment for a condition covered under this Certificate. Except, however, coverage is not provided when the sole reason that a Member is in a Hospital or any other facility is to receive speech, occupational, physical and/or respiratory therapy services.

Inpatient Speech, Occupational, Physical and Respiratory Therapy Services. If indicated on the attached Schedule of Benefits, Members are entitled to a limited number of inpatient days for Medically Necessary speech, occupational, physical and respiratory therapy. Such coverage is available only for rehabilitation following injuries, surgery or other medical conditions and is intended to improve or restore bodily function. Coverage is not provided to maintain the Member at his or her present level or to prevent further deterioration.

Speech, occupational, physical and respiratory therapy services received during an admission to a Hospital, rehabilitation facility or Skilled Nursing Facility do not count against the number of outpatient visits for such therapy as indicated on the attached Schedule of Benefits.

Inpatient Treatment of Mental Illness. Coverage for inpatient treatment of mental illness will be provided including professional services of psychiatrists and/or psychologists during the hospitalization. This benefit shall be limited to number of days indicated on the attached Schedule of Benefits.

Inpatient Alcohol and Substance Abuse Detoxification. Coverage for inpatient alcohol and substance abuse detoxification and related medical ancillary services will be provided when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. This benefit shall be limited to the number of days indicated on the attached Schedule of Benefits.

Inpatient Rehabilitation Treatment of Alcohol and Substance Abuse. If indicated on the attached Schedule of Benefits, benefits are available for a limited number of days for inpatient rehabilitation treatment of alcohol and/or substance abuse.

Copayment for Inpatient Hospital Care. The Member will not have to pay the Copayment for Inpatient Hospital Care indicated on the Schedule of Benefits more than once in each single confinement. A single confinement includes a readmission for the same or related condition within ninety (90) days of the discharge date of the previous admission.

OUTPATIENT HOSPITAL CARE

Covered Services. Subject to the Copay indicated on the attached Schedule of Benefits outpatient Hospital care shall consist of all services of Participating Providers as requested or directed by the PCP to be provided on an outpatient basis, including physical therapy, and radiation therapy, and services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy, ambulatory surgery, diagnostic and/or

treatment services; x-rays and laboratory and pathological tests. As in the case of inpatient care, ambulatory surgery must be approved in advance by the HIP Member Advocacy Program.

EXCLUSIONS AND LIMITATIONS

The following benefits are **NOT** covered under this Certificate:

- Private room. If a Member occupies a private room, he or she will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations.
- Private duty nursing.
- Non-medical items, such as television rental and telephone charges.
- Medications, supplies and equipment which the Member takes home from the Hospital or other facility.
- Any expense incurred for staying in the Hospital after the discharge time or date established by HIP or the Member's Physician.
- Care for the sole purpose of obtaining a non-covered benefit.

SECTION FIVE

MEDICAL SERVICES

Covered Services include, but are not limited to, consultant and referral services; primary and preventive care services; physician assistants; chiropractic services; in-Hospital medical services consisting of Physician services rendered to a Member who is a bed patient in a Hospital for treatment of a covered sickness or injury; surgical services consisting of operating and cutting procedures for the treatment of a sickness or injury, and endoscopic procedures, including any pre- and post-operative care; anesthetic services, including administration and related procedures in connection with covered surgical service rendered by a Physician; diagnostic service and treatment; dialysis treatment services; diabetes equipment, supplies and education; second surgical and medical opinions.

Office Visits. Services performed at a Participating Physician's office shall be subject to the applicable Copayment listed on the attached Schedule of Benefits. The member shall remit the Copayment at the time the person receives covered medical services from a physician or other provider in the office or in another ambulatory setting. However, the following services shall not be subject to a Copayment:

- Well child care visits, including immunizations.
- Pre-natal visits.
- X-ray and laboratory services.
- Second surgical and medical opinions.

The Member is entitled to the following Medical Services:

Preventive Health Services. This includes:

- Periodic physical examinations, clinical laboratory and radiological tests, ear and eye examinations, and all necessary health education and counseling services.

- Adult immunizations.

- Well child care services when ordered and performed by a Participating Provider shall be covered. These services include Physician-delivered or Physician-supervised visits from birth to 19, a medical history, a physical examination, developmental assessment and anticipatory guidance and appropriate immunizations (consisting of at least measles, rubella, mumps, haemophilus influenzae type b and hepatitis b which meet the standards approved by the United States Public Health Service for such biological products) and laboratory tests. Services including initial Hospital check-up and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law).

- One (1) baseline mammogram for any woman between thirty-five (35) and thirty-nine (39) years of age, inclusive.

- One (1) mammogram every two (2) Calendar Years, or more frequently, based on the Member's Physician's recommendation, for any woman who is forty (40) through forty-nine (49) years of age, inclusive.

- One (1) mammogram every Calendar Year if the Member is 50 years of age or older.

- One (1) or more mammograms per Calendar Year, based on Member's Physician's recommendation, for any woman who is at risk for breast cancer due to:

    I. a personal or family history of breast cancer;
    II. having a mother, sister or daughter who has had breast cancer; or
    III. a woman not having given birth before the age of thirty (30).

- One (1) cytology screening per Calendar Year for women age 18 or older, including an annual pelvic examination, collection and preparation of a Pap Smear, and laboratory and diagnostic services provided in connection with examinations and evaluating the Pap Smear.

Coverage for Newborn Children. Coverage for newborn children consists of coverage routine nursery care, injury or sickness, including necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity and transportation costs of the newborn to and from the nearest available facility

appropriately staffed and equipped to treat the newborn's condition, when such transportation is authorized by the attending Physician as necessary to protect the health and safety of the newborn child.

Diagnostic Services and Treatment. Services for diagnosis and treatment of disease and injury, including, but not limited to X-ray and laboratory procedures, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services are covered when provided on an outpatient basis and by Participating Providers.

Chiropractic Services. In accordance with the attached Schedule of Benefits, the Member is entitled to receive chiropractic services from a Participating Provider 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 in the vertebral column. A PCP referral for chiropractic services is not required.

Second Medical and Surgical Opinions. Members are entitled to a second medical or surgical opinion.

Second Medical Opinion (Cancer). Coverage is also provided under this Certificate for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. However, coverage shall be limited solely to a consultation visit and all follow up and diagnostic care shall be provided by a Participating Provider.

Subject to the limits indicated herein, Members may obtain a Second Medical Opinion (Cancer) from an appropriate Participating Physician, or from an appropriate Non-Participating Physician. In either case, however, a referral must be obtained from the Member's PCP or attending Participating Physician.

Dialysis Treatment Services. Members are entitled to receive Dialysis Treatment Services on a walk-in basis in a Participating Hospital or in a free-standing Participating Dialysis Facility appropriately licensed under state law. When Medically Necessary and Appropriate, Members are also entitled to receive peritoneal Dialysis Treatment Services at home, including the rental costs of equipment. However, this Certificate does not provide benefits for any furniture, electrical or other fixtures or for professional assistance needed to perform the dialysis treatments at home.

Dialysis Treatment Services are subject to the Copayment as indicated on the attached Schedule of Benefits.

Diabetes Equipment, Supplies and Education. Covered services include equipment and supplies provided by Participating Providers when recommended or prescribed for the treatment of diabetes by a Participating Physician or other Participating Provider authorized by law to prescribe:

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Lancets and automatic lancing devices*;*
- Test strips and control solutions for glucose monitors and visual reading and urine testing strips for glucose and ketones;
- Data management systems;
- Insulin, syringes, alcohol swabs, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices except that, investigational and experimental drugs and supplies, as determined by HIP, will not be covered;
- Insulin pumps and equipment for the use of the pump including batteries;
- Insulin infusion devices;
- Oral agents for controlling blood sugar, treating hypoglycemia such as glucose tablets and gels and glucagon for injection to increase blood glucose concentration;
- Additional Medically Necessary equipment and supplies, as may be required by law.

Members are also entitled to self-management education and diet information provided by Participating Physicians (or a licensed health care provider legally authorized to prescribe under New York State law), in connection with Medically Necessary and Appropriate visits, upon the diagnosis of diabetes, a significant change in the Member's symptoms, the onset of a condition necessitating changes in the Member's self-management protocols, or where it is determined by HIP that re-education is Medically Necessary and Appropriate.

Diabetes Education when provided by the following providers: Certified Diabetes Nurse Educator, Certified Nutritionist, Certified Dietician, Registered Dietician or other provider required by law. Such education may be provided in a group setting when practicable. When such education is provided as part of the same office visit as diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. Coverage will also be provided for home visits, when Medically Necessary and Appropriate.

Diabetic equipment and supplies are subject to the Copayment indicated on the attached Schedule of Benefits.

Medical Supplies. Coverage is provided for medical supplies that are required for the treatment of a covered disease or injury. Coverage for maintenance supplies (e.g., ostomy supplies) is also provided for covered conditions. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program prescribed by the Member's Physician. All supplies must be purchased from a Participating Provider.

Family Planning Services. Unless otherwise indicated on the Schedule of Benefits, Members are entitled to family planning services which shall consist of services and care related to elective termination of pregnancy, tubal ligation, vasectomy, and voluntary sterilization, contraceptive drugs and devices, including but not limited to the costs related to the measuring and fitting of a contraceptive device.

Direct Access Medical Services. Subject to the limits and copays indicated in this Certificate or the attached Schedule of Benefits, Members may obtain the following services from a Participating Provider without first obtaining a referral or approval in advance from his or her PCP and/or the HIP Member Advocacy Program:

- Chiropractic Services.
- Preventive and primary care services from the Member's PCP.
- Preventive obstetric and gynecological care including mammography screenings and cervical cytology screenings.
- Outpatient treatment of Mental Illness.
- Refractive eye exams from an optometrist.
- Diabetic eye exams from an ophthalmologist.

SECTION SIX

OUTPATIENT SPEECH, OCCUPATIONAL , CARDIAC, RESPIRATORY AND PHYSICAL THERAPY

Covered Services. Outpatient speech, occupational, cardiac, respiratory and physical therapy services are covered under this Certificate. Coverage is available only for rehabilitation following injuries, surgery or medical conditions to improve or restore bodily functions. Coverage is not provided to maintain the Member at his or her present level or to prevent further deterioration. Services shall be subject to the copay and number of visits as indicated on the attached Schedule of Benefits.

SECTION SEVEN

EMERGENCY SERVICES

Emergency Services. In the event of an Emergency Medical Condition, Members are covered for emergency care both in and outside the Service Area as well as with Participating Providers and Non-Participating Providers.

Continuing or Follow-Up Treatment. In its sole discretion, HIP may require the Member to obtain all continuing or follow-up treatment, whether in or out of the Service Area, from a Participating Provider.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Medical Condition requires notification to the HIP Member Advocacy

Program within ***forty-eight (48)*** hours of admission. This requirement shall not cause denial of an otherwise valid claim if the Member could not reasonably comply, provided that notification is given as soon as reasonably possible. Claims for an Emergency Medical Condition must be sent to HIP no later than forty-five (45) days after the service is provided. The claim shall contain supporting information, including an itemized statement of treatment, expenses and diagnosis. This requirement shall not cause denial of an otherwise valid claim if the Member could not reasonably comply, provided the claim and the supporting information are submitted as soon as reasonably possible.

Copayment for Emergency Medical Conditions. Emergency care shall be subject to the Copayment indicated on the attached Schedule of Benefits. If a Member is admitted to a Hospital as a result of an Emergency Medical Condition, the Emergency care Copayment indicated on the Schedule of Benefits shall be waived and the Inpatient Hospital Copayment shown on the attached Schedule of Benefits shall apply.

Ambulance Services. Members are entitled to Ambulance Services, provided such services are Medically Necessary and approved in advance by the HIP Member Advocacy Program or the use of Ambulance Services is determined to have been provided in connection with an Emergency Medical Condition.

Ambulance Services are not covered when transportation other than an ambulance (e.g. car, bus, chair car/van) could be used without endangering the patient's status. For example: transportation for routine care in a Physician's office or other facility. Also, transportation by ambulance of a deceased individual to the Hospital or morgue is covered when an ambulance has been called for an Emergency Medical Condition but the patient has expired prior to arrival of the ambulance.

Use of an air ambulance is limited. HIP will cover the use of an air ambulance only in the situation when ground transportation is not Medically Appropriate for the condition or circumstance. Non-emergent air transportation always requires approval in advance by the HIP Member Advocacy Program.

SECTION EIGHT

OUTPATIENT TREATMENT OF MENTAL ILLNESS

Covered Services. Services of Participating Providers qualified to treat Mental Illness are available on an outpatient basis subject to the Copayment and number of visits per Calendar Year as indicated on the attached Schedule of Benefits. Members may obtain outpatient treatment of mental illness from a Participating Provider on a direct basis, without a PCP referral. Please refer to your HIP Member Handbook for details on how to make an appointment with a Provider for these services.

In determining benefits available, services rendered for the treatment of any physiological conditions related to a Mental Illness, or rehabilitation services for alcohol or drug abuse or addiction, will not be considered to be services for treatment of a Mental Illness.

SECTION NINE

OUTPATIENT REHABILITATION TREATMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

Covered Services. Coverage is provided for the outpatient diagnosis and rehabilitation treatment of alcoholism and/or substance abuse subject to the Copayment and number of visits as indicated on the attached Schedule of Benefits. Covered Services shall include outpatient family and group therapy by psychiatrists, psychiatric social workers, psychologists, alcoholism counselors or other staff members of a Participating Mental Health Facility.

Within New York State, the care must be received from an appropriately certified facility, depending upon the Member's primary diagnosis. If the primary diagnosis is alcoholism, the facility must be certified by the New York State Division of Alcoholism and Alcohol Abuse. If the primary diagnosis is substance abuse, the facility must be certified by the New York State Division of Substance Abuse Services as a medically supervised ambulatory substance abuse program.

Outside of New York State, benefits will be provided for services that are received in a facility whose alcoholism and substance abuse treatment program has been approved by the Joint Commission on the Accreditation of Healthcare Organizations.

SECTION TEN

HOME HEALTH CARE SERVICES

Covered Services. Medically Necessary and Appropriate Home Health Care Services are covered for a Member who requires Skilled Care and is in lieu of care in a Hospital or Skilled Nursing Facility. Coverage is provided only to the extent determined solely by HIP to be in accordance with the standards of generally accepted medical practice and is not provided primarily for convenience of the Member. Home Health Care services shall be subject to the Copayment and number of visits as indicated on the attached Schedule of Benefits.

Skilled Care means care or services that require the skill of a licensed medical professional, are reasonable and necessary for the treatment of the condition, are within the scope of appropriate home care practice and are provided in accordance with a Physician-approved plan.

Home Health Care services shall be provided by a certified home health agency which is a Participating Provider. Home Health Care Services include visits by professional nurses and other licensed health professionals, disposable medical supplies and durable medical equipment administered or used by such persons in the course of services

rendered during such visits, drugs and medications prescribed by a Participating Physician, and physical, occupational and speech therapy provided in the home.
Coverage is not provided for care which HIP, in its sole judgment, determines to be primarily custodial. Custodial care is care which does not require the continuing attention of trained medical personnel. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include but are not limited to:

- Assistance in meeting activities of daily living, such as feeding, dressing and personal hygiene;
- Administration of oral medications, routine changing of dressing or preparation of special diets; or
- Assistance in walking or getting in or out of bed.

These services are considered custodial even if the Member cannot provide this care for himself or herself because of age or illness and even if there is no one in the Member's household who is able or willing to provide these services.

SECTION ELEVEN

SKILLED NURSING FACILITY SERVICES

Covered Services. Benefits will be available for Skilled Nursing Facility Services, when approved in advance by the HIP Member Advocacy Program, and shall include continued care and treatment of a Member provided such care is:

- In a Skilled Nursing Facility;
- Hospitalization would otherwise be necessary; and
- The Member must require skilled care, as defined in Section Eleven above, which is required on a daily basis, is not primarily custodial as defined in Section Eleven above, and can only be provided on an inpatient basis.

A Skilled Nursing Facility is a licensed facility that is approved for participation as a Skilled Nursing Facility under Medicare and certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations. HIP will not, under any circumstances, provide Skilled Nursing Facility Services for a facility which is primarily used as a rest home, a home for the aged, or a facility for the treatment of alcoholism, substance abuse or Mental Illness.

Subject to the criteria above, Skilled Nursing Care is subject to the Copayment and number of days shown on the attached Schedule of Benefits. However, if the Member requires only skilled physical therapy or rehabilitation and does not otherwise require skilled nursing care on an inpatient basis, the skilled therapy or rehabilitation benefits will be limited to the number of outpatient physical therapy visits indicated on the attached Schedule of Benefits.

SECTION TWELVE

HOSPICE CARE SERVICES

Covered Services. Coverage is provided for Hospice Care Services in an approved Hospice Care Program, due to Terminal Illness. Hospice Care Services shall include inpatient care; outpatient services; professional services of a Physician; prescription drugs and medical supplies provided by the Hospice Program; five (5) visits of bereavement counseling for family members of the Terminally Ill Member, whether before or after the Member's death; and Home Health Services. Hospice Care Services are subject to the Copayment and number of days indicated on the attached Schedule of Benefits.

Hospice Care Services do not include the following:

- Services of a person who is the patient's family member or who normally resides in the patient's house;
- Services or supplies not listed in the Hospice Care Program;
- Services for which any other benefits are available under this Certificate.
- Services or supplies that are primarily to aid the patient or patient's family in daily living;
- Services for respite care;
- Nutritional supplements, non-prescription drugs or substances, vitamins or minerals and prescription drugs not provided by the Hospice Program.

SECTION THIRTEEN

EXCLUSIONS AND LIMITATIONS

In addition to certain exclusions and limitations already described in this Certificate, benefits will not be provided under this Certificate when any of the following apply:

Alternative Medicine – Benefits are not available for services, testing, equipment, and supplies associated with alternative modalities of care including, but not limited to acupuncture, hypnosis, biofeedback, naturopathy, homeopathy, massage therapy, and aromatherapy.

Blood – Benefits are not available for the drawing and storage of blood and blood products, unless taken from a member preoperatively for an approved surgical procedure or for blood products and storage.

Care Ordered by a Court of Law or any governmental agency that would not otherwise be covered under this Certificate is not available.

Care Provided Outside of the HIP Service Area – Benefits are not available for services provided when the Member is traveling, visiting, or temporarily residing outside

of the Service Area, except for Emergency Medical Conditions as defined in this Certificate.

Cosmetic Surgery - Benefits are not available for any professional services and/or hospitalization in connection with elective cosmetic surgery, including but not limited to, rhinoplasty, liposuction, abdominoplasty, breast reduction mammoplasty, blepharoplasty, varicose vein injections, removal of nevi, cherry angiomas, telangiectasias, and spider angiomas. However, benefits may be available for reconstructive surgery if it is incidental to or follows surgery from trauma, infection or other diseases of the part of the body involved. With respect to a child covered under this Certificate, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.

Custodial Care - Benefits are not available for hospital care, nursing home care, skilled nursing facility care or home health care that is primarily or wholly custodial.

Dental Care - Benefits are not available for dental care, except treatment required in connection with an accidental injury to sound natural teeth if the service is provided within twelve (12) months after the accident. However, orthodontics and fixed and removable prosthetics are not covered under this Certificate.

Disposable Medical Supplies and Personal Convenience - Benefits are not available for supplies, equipment, or personal convenience items such as, but not limited to, combs, lotions, bandages, alcohol pads, incontinence pads, surgical face masks, disposable sheets and bags or the use of telephones or television while an inpatient.

Durable Medical Equipment – Benefits are not available for durable medical equipment, including, but not limited to wheelchairs and hospital beds.

Educational Materials and Supplies - Benefits are not available for educational materials and supplies commonly available for purchase such as diet and nutritional books or magazines or literature about medical conditions and treatments.

Eye care – Benefits are not available for eyeglasses and/or contact lenses unless indicated on the attached Schedule of Benefits. Benefits are not available for radial keratotomy and other intended procedures to correct eyesight. However, eyeglasses and/or contact lenses used solely for treatment of keratoconus or in post-cataract surgery for aphakia cases shall be covered.

Experimental and/or Investigational Treatments and Procedures - Benefits are not available for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure, or treatment will be determined to be experimental if any of the following applies:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

- The FDA has not granted the required approval for general use;
- A recognized national medical or dental society or regulatory agency has determined in writing, that it is experimental, investigational, or for research purposes;
- The written protocols or informed consent used by the treating facility or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure, or treatment state that it is experimental, investigational or for research purposes.

Also, this Certificate does not cover any Technology or any hospitalization in connection with such Technology if, in HIP's sole judgment, such Technology is obsolete or ineffective and is not used generally by the medical community for the diagnosis or treatment of the particular condition. Governmental approval of a Technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a diagnosis or treatment of a particular condition.

If HIP has denied coverage on the basis that the service is an experimental or investigational treatment, the Member or his or her representative may appeal that decision to an External Appeal Agent, an entity certified by the State of New York to conduct such appeals. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, HIP will only cover the costs of services required to provide treatment to the Member according to the design of the trial. HIP will not be responsible for the costs of managing research, or costs that would not be covered under this Certificate for non-experimental or non-investigational treatments. For additional information on External Appeals, please consult the HIP Member Handbook.

Free Care and Care Provided by Family Members – Benefits are not available for any care if the care is furnished to the Member without charge or would normally be furnished to the Member without charge if he or she were not covered under this Certificate or under any other insurance. No benefits are provided for services rendered by an immediate family member of a person covered under this Certificate.

Government Hospital - Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the Hospital is a Participating Hospital. However, this exclusion does not apply to the United States Veterans -Administration or Department of Defense hospitals, except for care provided in connection with a service-related disability. In addition, benefits are provided for care covered under this Certificate in such a Hospital if, because of an Emergency Medical Condition, if the Member is taken to one of these Hospitals for emergency care. In this instance, we will continue to cover services only for as long as emergency care, in our sole judgment, is Medically Necessary and Appropriate and it is not possible for the Member to be transferred to a Participating Hospital.

Government Programs - Benefits are not available for any service that is covered, and payment is therefore available to the Member, under any federal, state or local government program, except that we will pay even though the Member is eligible for Medicaid.

Hearing Aids. Benefits are not available for hearing aids. However, cochlear implants are covered when Medically Necessary and Appropriate.

Home Hemodialysis – Benefits are not available for any furniture, plumbing, electrical or other fixtures needed to perform dialysis treatments at home. Only home peritoneal dialysis is covered.

Home Oxygen Equipment – Benefits are not available for certain home oxygen equipment items including, but not limited to, emergency oxygen inhalators, portable preset oxygen units, and oxygen administration equipment.

Immunizations – Benefits are not available for immunizations including, but not limited to, autogenous vaccines and adult immunizations related to foreign travel. Coverage is provided for childhood immunizations, pneumococcal and flu vaccinations, and immunizations required because of an injury or immediate risk of infection.

Learning Disorders - Benefits are not available for learning disorders including special education, vocational rehabilitation, neuropsychological testing, braille teaching, sleep therapy, behavioral training, employment counseling, psychological counseling and educational therapy for conditions related to the learning disorders or developmental delays, including, but not limited to conditions such as mental retardation, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), pervasive deficit disorder (PDD), and dyslexia.

Medical Necessity – Benefits are not available for any service, supply, diagnostic test, surgical procedure or treatment which HIP, in its sole discretion, determines is not Medically Necessary and Appropriate.

If HIP has denied coverage on the basis that the service is not Medically Necessary, the Member or his or her representative may appeal that decision to an External Appeal Agent, an entity certified by the State of New York to conduct such appeals. If an External Appeal Agent overturns the denial, HIP will cover the procedure, treatment, service, pharmaceutical product or durable medical equipment for which coverage had been denied, to the extent that the procedure, treatment, service, pharmaceutical product or durable medical equipment is otherwise covered under the terms of this Certificate. For additional information on External Appeals, please consult the HIP Member Handbook.

Mental Health Benefits – Benefits are not available for a mental or nervous disorder, except as otherwise provided under this Certificate.

No-Fault Automobile Insurance - Benefits are not available for any service that is covered by mandatory automobile no-fault benefits. HIP will not provide any benefits even if the Member does not claim the benefits he or she is eligible to receive under the no-fault automobile insurance.

Non-Participating Providers - Except in Emergencies, or as indicated in this Certificate or on the attached Schedule of Benefits, Members are entitled to benefits for services only when provided or arranged by the PCP or other treating Physician.

Nutrition – Benefits are not available for nutritional services, all supplements (unless they are the sole source of nutrition) or nutrition replacement products that are primarily intended for weight control, diet or weight-reduction programs including, but not limited to diet clinics or the diet clinic's required lab work and X-rays, physician visits, and any testing performed in relation to a liquid protein or other diet, except for diabetes self-management education as indicated in this Certificate.

Orthognathic Surgery – Benefits are not available for development or occlusion-only related treatment that is not considered medically necessary; reconstruction for ridge atrophy or dental alveolar loss; treatment for mandibular prognathism, retrognathism, or asymmetry not considered medically necessary; treatment for maxillary hyperplasia, hypoplasia, asymmetry or apertognathia not considered Medically Necessary; surgical augmentation for orthodontics; orthognathic surgery to correct non-Medically Necessary malocclusions or for cosmetic reasons; pre-prosthetic surgery: surgical preparation of the mouth for the insertion of dentures to include jaw augmentation or implants.

Pharmacy – Benefits are not available for prescription drugs, except medications administered in the course of covered treatment by the Member's Physician during an office visit and immunosuppressive drugs for one (1) year after a covered organ transplant and drugs administered in the course of covered treatment.

Photography – Benefits are not available for photographs, slides, movies or video tapings and services of medical photographers even when required to make a benefit determination.

Physical Examinations – Benefits are not available for physical examinations in order to obtain employment or insurance, for medical research, or for camp, school, immigration, fitness and other programs.

Routine Foot Care – Benefits are not available for routine, non-diabetic related foot care, including, but not limited to, simple trimming, cutting, or clipping of the distal nail plate and treatment of corns and calluses.

Temporomandibular Joint (TMJ) Syndrome – Benefits are not available for any diagnostic studies or treatment in connection with temporomandibular joint syndrome (TMJ) or disease, except treatment that is considered Medically Necessary and/or is

incidental to or follows surgery from external trauma, infection or other diseases of the part of the body involved.

Transportation – Benefits are not available for transportation for reasons not related to an Emergency Medical Condition. There is no benefit for ambulance service, ambulette service, transfers, or transport for patient or family convenience.

Unapproved Services. HIP will not provide benefits for any service or care unless treatment is performed, prescribed, approved in advance or referred by the PCP and/or HIP or its designee, unless otherwise indicated in this Certificate.

Workers' Compensation. No benefits are available for any injury, condition or disease if payment is available to the Member under a Workers' Compensation Law or similar legislation. HIP will not provide benefits even if the Member does not claim the benefits he or she is eligible to receive under the Workers' Compensation Law.

The following services, treatments and benefits are also excluded under this Certificate:

- Services required for a condition arising out of participation in a felony, riot or insurrection, suicide or intentionally self-inflicted injury. However, benefits are available for mental health services in connection with attempted suicide.

- Foot orthotics.

- Services required by participation in a war or act of war, whether declared or undeclared or by international armed conflict.

- Surgery or any related care (or after care) in connection with gender transformation.

- Services and supplies related to infertility treatment, including but not limited to artificial insemination, reversal of sterilization (male or female), any costs related to donors or semen banks, in-vitro fertilization or other artificial means of conception. Except that treatment for conditions that result in infertility are covered.

SECTION FOURTEEN

COORDINATION OF BENEFITS

This Section applies to Subscribers and members of their families covered under this Certificate ("This Plan") who also have health benefits coverage under another group health benefits plan whether insured or self-insured, including HMOs, point of service plans, preferred provider organizations, indemnity and other group coverage (the "Other Plan"). In all cases, however, HIP will only coordinate benefits for Covered Services.

Rules to Determine Payment. The following rules apply to determine which plan shall be primary:

A. If the Other Plan does not have a provision similar to this one, then it shall be primary.

B. If the Member receiving the benefits is the person belonging to the group through which This Plan was issued and is covered as a dependent under the Other Plan, This Plan will be primary.

C. If a dependent child is covered under plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. However, if the Other Plan does not have this birthday rule but instead has a rule based on gender of the parent and as a result the plans do not agree on which is primary, then the rule in the Other Plan shall determine the order of benefits.

D. If a dependent child is covered by both parents' plans, the parents are separated or divorced and there is no court decree which establishes financial responsibility for the child's health care expenses:

    1. the plan of the parent who has custody (the custodial parent) shall be primary;
    2. if the custodial parent has remarried, and the child is also covered as a dependent under the stepparent's plan, the custodial parent's plan shall pay first, the stepparent's plan shall pays second and the non-custodial parent's plan shall pay third.

    If a court decree specifies which parent is to be responsible for the child's health care expenses and that plan has actual knowledge of the decree, then the Other Plan shall be primary.

E. If a Member is covered under one plan as an active employee, or as the dependent of an active employee and the same Member is covered under another plan as a laid-off or retired employee or as the dependent of such laid-off or retired employee, then the plan which covers the Member as an active employee or the dependent of such active employee shall be primary. However, if the Other Plan does not have this rule in its coordination of benefits provisions, and as a result the plans to not agree on which plan shall be primary, then this rule shall be ignored.

F. If none of the above rules determine which plan shall be primary, the plan which covered the Member for the longer period shall be primary.

Effects of Coordination. When This Plan is secondary, the benefits of This Plan will be reduced by the amounts paid or provided by the primary plan(s) for the same item of service. The amount This Plan will pay or provide will not be more than the amount it would pay if it were primary.

Private Room Difference. Regardless of whether This Plan is primary or secondary, This Plan will not pay or provide benefits for the difference between the cost of a private hospital room and the cost of a semi-private hospital room unless a private room is Medically Necessary and for a benefit covered under this Certificate.

Right to Receive and Release Necessary Information. HIP has the right to release or to receive information that it needs to carry out the purposes of this Section**.** HIP does not need to inform the Member or to obtain anyone's consent to do this, except as may be required by under applicable state and/or federal laws. HIP will not be legally responsible to the Member or anyone else for releasing or obtaining this information. Members must furnish to HIP any information that HIP requests for carrying out the purpose of this Section. If such requested information is not provided, HIP reserves the right to deny payments for the services in question.

Right to Recover Overpayments. In some cases, HIP may have made payment or provided benefits even though the Member had coverage under another plan. Under these circumstances, the Member agrees to refund to HIP the amount by which HIP should have reduced the payment or benefit. HIP also has the right to recover any overpayments from the Other Plan or any Providers and the Member agrees to sign all documents necessary to help recover any overpayments.

Subrogation and Right of Recovery. Immediately upon paying or providing any benefit hereunder, HIP shall be subrogated to all rights of recovery a covered person has against any third party, to the full extent of benefits provided by HIP. In addition, if a covered person receives any payment from any third party as a result of an injury, HIP has the right to recover from, and be reimbursed for all amounts paid hereunder and will pay as a result of any illness or injury, up to the amount the covered person has received from all third parties, provided that the settlement or judgment the covered person receives specifically identifies or allocates monetary sums directly attributable to expenses for which HIP provided as benefits.

As used throughout this provision, the term "third party" means any party possibly responsible for making any payment to the covered person for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term "covered person" means the injured person or persons or any of their agent, representatives, assignees, guardians, heirs or beneficiaries.
The covered person shall do nothing to prejudice HIP's subrogation and reimbursement rights and shall, when requested, cooperate with HIP's efforts to recover its benefits paid. It is the duty of the covered person to notify HIP within 45 days of the date when any

notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person. The penalty for failing to cooperate as indicated above is that the covered person will be responsible to repay to HIP the cost of the benefits and services provided.

Medicare Eligibility. This Plan is not intended to duplicate any coverage for which Members are, or could be eligible for, such as Medicare. Members agree to complete and submit to HIP any documentation reasonably necessary for HIP to receive or assure reimbursement under Medicare.

- If a Member's Group has 20 or more employees, any active employee or spouse of an employee who becomes or remains a member of the Group after becoming eligible for Medicare due to reaching the age sixty-five (65), will receive the benefits under this Certificate as primary unless such Member elects Medicare as his or her primary coverage. However, the Member or the Member's Group must notify HIP in writing of the election. Any Member who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of such election unless the Member's coverage under this Certificate continues under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act (DEFRA) and/or COBRA. If the Member elects Medicare as primary, he or she may submit an application to enroll in the HIP VIP Medicare Plan and receive Medicare benefits through HIP. If the Member does not elect Medicare as primary and maintains his or her coverage under this Certificate, he or she may simultaneously enroll in the HIP VIP Medicare Plan for secondary coverage.

  Members eligible for Part A and Part B of Medicare will not receive the benefits of this Certificate already provided by Medicare Parts A and B. This applies even if the Member fails to claim the benefits available under Medicare.

- If a Member's Group has 100 or more employees or the Group is an organization which includes an employer with 100 or more employees, any active employee, spouse or an active employee or Dependent child of an active employee who becomes or remains a Member of the Group and is covered under this Certificate, after becoming eligible for Medicare due to disability, including, but not limited to end stage renal disease (ESRD), will receive the benefits of this Certificate as primary unless such person elects Medicare as his or her primary coverage. However, the Member or the Group must notify HIP in writing of the election. Any Member with ESRD, who enrolls in Medicare but does not elect Medicare as primary, would, nonetheless, receive Medicare benefits as primary after the Medicare coordination period. If the Member elects Medicare as primary, he or she may submit an application to enroll in the HIP VIP Medicare Plan and receive Medicare benefits through HIP. If the Member does not elect Medicare as primary and maintains coverage under this Certificate, he or she may simultaneously enroll in the HIP VIP Medicare Plan for secondary coverage.

- Any Members not subject to either of the above two provisions, and who are eligible for Medicare, will not receive the benefits of this Certificate already provided by Medicare Parts A and B. This applies even if the Member fails to claim the benefits available under Medicare. If the Member elects Medicare as primary, he or she may submit an application to enroll in the HIP VIP Medicare Plan and receive Medicare benefits through HIP. If the Member does not elect Medicare as primary and maintains coverage under this Certificate, he or she may simultaneously enroll in the HIP VIP Medicare Plan for secondary coverage.

SECTION FIFTEEN

TERMINATION OF COVERAGE

Member Termination. A Member's coverage under this Certificate will terminate upon any of the following:

- Termination for any reason whatsoever of employment or membership in the Group.
- Termination for any reason whatsoever of this Certificate by the Group.
- Upon thirty (30) days notice for any fraud, intentional misrepresentation or omission, or the giving of false information by a Member, in applying for this coverage and in filing any claim for coverage under this Certificate.
- Ninety (90) days after a Member moves outside of HIP's Service Area.
- Upon Death of the Subscriber. Coverage will automatically terminate upon the death of the Subscriber. However, if the Subscriber elected family coverage, coverage under this Certificate will terminate on the date to which the premium is paid by the group.
- Termination of Marriage. If the Subscriber becomes divorced or his or her marriage is annulled, the coverage of the dependent spouse under this Certificate will automatically terminate on the date of the divorce or annulment.

Termination of Coverage of a Child. The coverage of a child under this Certificate will automatically terminate when the child marries, reaches the age shown on the Schedule of Benefits, whichever comes first, or is no longer an unmarried Full Time Student under the age shown on the Schedule of Benefits at an accredited institution. The coverage will terminate as of the end of the [**month or year**] in which the child no longer meets these conditions, or date of marriage, whichever comes first.

If the Subscriber is no longer covered under this Certificate. This coverage will terminate on the date indicated if one of the following happens:

- On the date up to which the Subscriber's premium is paid if he or she is no longer a member of the Group. For example, if employment in the group terminates on June 15 and premium has been paid by the Group up to July 1, this coverage will terminate on July 1.

SECTION SIXTEEN

EXTENSION AND CONTINUATION OF COVERAGE

Extension of Benefits after Termination Upon Total Disability. In the event coverage is terminated under this Certificate and the Member is Totally Disabled on the effective date of termination, the Member will be entitled to continue to receive benefits under this Certificate for the treatment of the condition or illness resulting in the Total Disability until the earlier of:

- Twelve (12) months from the effective date of the termination of coverage;
- The Member receives the maximum benefit under the Certificate; or
- The Member is no longer totally disabled as a result of the condition or illness which existed and manifested itself as of the effective date of the termination of coverage.

Extension of Coverage for Handicapped Children. The coverage of an unmarried Dependent child will be continued past the age limitation for such coverage if (s)he is:

- Incapable of self-sustaining employment because of physical handicap or mental illness, mental retardation or developmental disability as defined under applicable state laws.
- Incapacitated prior to age indicated on the Schedule of benefits.

Coverage will continue as long as this Certificate remains in force and the Subscriber remains eligible and covered under this Certificate and all required premiums have been paid. The Subscriber has the burden of establishing that the child continues to meet the criteria above. HIP may require proof that the child remains eligible for coverage under this Certificate. Failure to submit the required proof may result in termination of coverage.

Continuation of Coverage. Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA) which is applicable to Groups covering more than 20 Members, and New York State continuation coverage laws which are applicable in lieu of COBRA, Subscribers and their Dependents have the opportunity for a temporary continuation of health coverage when they lose coverage under one of the events below:

A. If the Subscriber loses coverage due to termination of employment or reduction of hours, the Subscriber and his or her dependents may elect continuation coverage for 18 months. If the Subscriber becomes eligible for Medicare during these 18 months, his or her covered dependents may extend the coverage up to 36 months. If the Subscriber is disabled on the date of loss of group coverage, he or she may elect continuation for 29 months.

B. If the Subscriber is a retiree or a retiree's widow(er) and the Group commences bankruptcy proceedings, he or she may elect continuation coverage until death.
C. If the Subscriber becomes eligible for Medicare, dies, divorces or legally separates from a spouse covered under this Certificate, the former spouse and the dependent child(ren) may elect continuation coverage for 36 months.
D. HIP or the Group will send eligible Members an election notice when group coverage terminates. Eligible Members have sixty (60) days to make the election and forty-five (45) days from the date of election to pay the first premium. The Member must then remit future payments in a timely manner.

Continuation coverage is available for the periods described above, but will terminate earlier if:

- The Group stops providing health coverage to its employees.
- The date any required premium is due but not paid on time.
- The Member becomes covered under another group health plan, except that if the Other Plan imposes a pre-existing conditions limitation period, the Member may continue his or her coverage until the 18, 29 or 36 months expire.
- The Member becomes entitled to Medicare (unless he or she elected continuation coverage due to the Group's bankruptcy).

HIP is not the Plan Administrator under COBRA, unless HIP assumes that obligation under a separate agreement with the Group. HIP shall rely solely on the Group's determination of a Member's eligibility for continuation coverage. COBRA is regulated by the U.S. Department of Labor. Members must refer to the Group to see if COBRA applies. HIP will assume no liability for any damages resulting from the Group's non-compliance with any COBRA requirement or regulation.

Family and Medical Act. If a Member is eligible for a medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), he or she may continue coverage for up to 12 weeks during a twelve (12) month period, as defined by the Group. Members must refer to the Group Administrator to see if FMLA applies.

SECTION SEVENTEEN

RIGHT TO A NEW CONTRACT

Upon termination of coverage under this Certificate, Members may choose to continue coverage pursuant to Section Sixteen above or to purchase a direct payment contract pursuant to this Section. If a Member chooses to continue coverage pursuant to Section Sixteen above, then he or she may purchase a direct payment contract when continuation coverage is exhausted.

Upon request, HIP will send a direct payment contract application, benefit summaries and other required information regarding its direct payment plans. HIP must receive, by certified mail, return receipt requested, a completed application and any premium due

within forty-five (45) days after coverage terminates under this Certificate. This forty-five (45) day period may be extended if notice is not given on a timely basis.

In the event that the application is not received, or any required premium is not received, within sixty-three (63) days the individual shall lose all Creditable Coverage and may be subject to Pre-Existing Conditions limitations.

The new contract will be the standardized HMO or Point-of-Service contract required to be sold on a direct payment basis by the New York State Insurance Department.

SECTION EIGHTEEN

DISPUTES UNDER THIS CERTIFICATE

Grievance and Appeals. Members should refer to the HIP Member Handbook for a detailed description of the HIP Grievance and Appeal Procedures.

Choice of Law. In any dispute with HIP, the law of the State of New York or federal law, as appropriate, shall be applied to determine the rights of all parties hereunder.

External Reviews. Members should refer to the HIP Member Handbook for a detailed description of the external review policies and procedures.

Time to Sue. Any lawsuit under this Certificate must commence within one (1) year from the date of the service in question. Any legal action must be commenced in the State of New York.

SECTION NINETEEN

GENERAL PROVISIONS

No Assignment. Benefits and payments under this Certificate cannot be assigned to any person, corporation or other organization. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of a right to the benefits and services under this Certificate or the right to receive payment from HIP for those services.

Notices. Any notice under this Certificate will be mailed to the Group. Also, certain Member notices required under this Certificate may also be mailed to the Group. Any notice required to be sent to HIP should be sent to 7 West 34th Street, New York, New York 10001.

Medical Records. From time to time it may become necessary for HIP to obtain a Member's medical records and information providers, as well as other insurers or group health plans. All HIP Members under this Certificate, agree and authorize HIP,

Participating Providers and non-Participating Providers to permit the examination and copying of any portion of said Members' Hospital or medical records, when requested by HIP. All Members enrolling with HIP expressly authorize HIP to obtain and use such information consistent with the administration of this Certificate. Additionally, if potential fraud is suspected, HIP has the right, without consent of the Member or Group, to review, including but not limited to, medical records, enrollment records and other relevant information needed to verify services.

Confidentiality of Medical Records. Medical records are confidential documents containing information about a Member's medical treatment. To protect medical records so that they are only released in accordance with all applicable laws and only to people who are properly identified and legally authorized, HIP has established a series of policies and procedures that are based on sound business practices and legal requirements. Strict confidentiality standards are adhered to at HIP concerning patient medical records.

- New HIP employees are instructed in medical record confidentiality requirements. They must sign a confidentiality statement of understanding. Each year of their employment, they must reaffirm their understanding of the importance of HIP's medical record confidentiality policy.

- To manage the security and routing of Member medical records, Participating Providers must also maintain medical records departments that are regularly instructed in and observe confidentiality procedures.

- HIP may receive copies of Member medical records during the course of business, such as when a claim is submitted. Copies of medical records are securely stored and reviewed only by designated employees with a need to know the information. As soon as the specific need has been fulfilled, copies of medical records are securely filed or destroyed.

Who Receives Payment. Payments under this Certificate for covered services may be made directly to the Physician, Hospital or other provider that rendered the services. HIP reserves the right to pay either the Member or the provider directly.

Relationship with Participating Providers. The HIP Participating Physicians and other Participating Providers are not agents or employees of HIP. They are solely responsible for the medical care and other services they provide. HIP DOES NOT PROVIDE MEDICAL CARE. It is the obligation of HIP under this Certificate to provide Members with access to care and/or to pay for Covered Services in accordance with the terms of this Certificate. HIP is not responsible for any act or omissions of any HIP Participating Physician or other Participating Provider.

Referrals to Nonparticipating Providers with Specialty Expertise. If HIP does not have a Participating Provider with the appropriate training and experience to meet the particular health care needs of a Member, the Member may obtain a referral to a health care provider outside of HIP's network of Participating Providers. The Member must

first seek care through his or her HIP PCP and any specialists referred by the PCP. Then, if the PCP determines that the Member requires a referral to a Non-Participating Provider, the PCP will refer the Member for such a specialty consultation. The PCP will develop a treatment plan with the Member and the Non-Participating Provider. Once the plan is approved by HIP, this care will be provided to the Member as if the Non-Participating Provider were a HIP Participating Provider. The Non-Participating Provider must agree to accept HIP's usual rates as payment in full.

Standing Specialty Referrals & Specialists as Coordinators of Care. If a Member has a condition or disease that needs the ongoing care of a specialist, a standing referral to see that specialist can be arranged. A standing referral means that the Member may make an appointment with and see his or her specialist directly.

For a standing referral, the HIP PCP must determine that such a referral is appropriate. The Member will then be referred for a specialty consultation and a treatment plan will be developed with the Member and his or her PCP. HIP will need to authorize the specialist's treatment plan in advance. The treatment plan may limit the number of visits allowed or the period of time in which the Member can go to the specialist for treatment of the particular condition. The specialist may also be required to provide the PCP with regular updates on the care provided as well as all necessary medical information. Once approved, the Member will receive the treatment under the treatment plan.

If the Member has a life-threatening or degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time, he or she may need a specialist with the capability and expertise in treating the particular condition or disease to be responsible for providing and coordinating both primary and specialty care. In such a case, the Member will be referred for a specialty consultation and if the PCP, in consultation with the specialist, determines that both primary and secondary care would be more appropriately provided and coordinated by the specialist, an appropriate treatment plan will be developed. HIP must then authorize the specialist's treatment plan. Once approved, the Member will receive the treatment under the plan.

In both cases described above, as long as the specialty care required by the Member is available from the HIP network of Participating Providers, the Member will not be approved to go to a Non-Participating Provider for care. However, if no Participating Provider is available with the training and experience to meet the Member's particular health needs, he or she will be approved to receive care from a Non-Participating Provider. With this approval, the Member will have no additional cost beyond what he or she would pay for the services if rendered by a Participating Provider.

Access to Specialty Care Centers. If a Member has a life-threatening or degenerative and disabling disease or condition that requires special medical treatment for a prolonged period of time, he or she may need to go to a center that specializes in the care of the particular condition. Specialty care centers are those centers designated as having expertise in the treatment of life-threatening or degenerative and disabling diseases or conditions by an agency of the state or federal government or by a voluntary national health organization.

If the Member's HIP PCP or Participating Physician (if a specialist has been assigned to coordinate both primary and specialty care) determines that treatment at a specialty care center would be most appropriate, then a referral to such a center can be arranged. That arrangement will be made by the PCP. HIP must authorize the specialty care center's treatment plan in advance. If no specialty care center for the particular disease or condition is available in the HIP network of Participating Providers, the Member will be referred to a non-participating specialty care center. In this case, the Member will have no additional cost beyond what he or she would pay for the services if rendered by a Participating Provider.

Notice and Transitional Care If A Physician Is No Longer In The HIP Network of Participating Providers. HIP will provide a Member with written notice within 15 days of learning that the Member's PCP will no longer be a HIP Participating Provider. HIP will also provide a Member with similar notice if any of other Physician ceases to be a HIP Participating Provider and the Member is receiving on-going care from that Physician and HIP is aware of the treatment. The notice will describe how the Member may continue to receive care from that Physician during a transitional period after which care will be provided by a new HIP Participating Provider.

Should a Member's HIP Participating Provider become a Non-Participating Provider for any reason (other than for reasons relating to impairment of the provider's license to practice), HIP will allow the Member to continue an ongoing course of treatment with this provider for up to 90 days from the date the Member is notified of the provider's status as Non-Participating. If a Member is in her second trimester of pregnancy, the transitional period will include post-partum care directly related to the child's delivery.

This transitional care requires prior approval and shall be approved by HIP only if the health provider:

- Continues to accept HIP's rates of reimbursement for the Member's care.

- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to the Member's care.

- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior approval requirements.

Transitional Care For New Members Receiving Ongoing Treatment. If the Member is a newly enrolled HIP member whose health care provider is not in the HIP network of Participating Providers, HIP will permit the Member to continue an ongoing course of treatment with his or her current provider under certain circumstances and for a limited period of time. HIP will allow a transitional period of up to 60 days from the Member's effective date of enrollment as an aid towards transitioning care to a new HIP Participating Provider. This transitional care will be covered only if the Member has a life threatening or degenerative, disabling disease or condition. If the Member is in her second trimester of pregnancy, the transitional period will include post-partum care directly related to the child's delivery.

If a Member elects to continue to receive care from his or her current provider during this transitional period, HIP's prior approval is required. HIP will authorize this care only if the provider agrees to:

- Accept HIP's reimbursement rates as payment in full for the services provided to the Member.

- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to the Member's care.

- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior approval requirements.

The above shall not require HIP to provide coverage for care which may otherwise be excluded due to a Pre-existing Condition limitation or any other exclusion or limitation contained in this Certificate and any Amendments and/or Riders hereto.