Gupta | Wessler *Issues & Appeals*

April 12, 2022

Judy Keenan
Director
New York District
Equal Employment Opportunity Commission
33 Whitehall Street, 5th Floor
New York, NY 10004
United States

Re: *Corey Briskin and Nicholas Maggipinto v. City of New York*

Dear Director Keenan,

I represent Corey Briskin, a former employee of the City of New York, and his husband Nicholas Maggipinto, who were denied equal treatment by the City of New York, which categorically excludes gay male employees from receiving in vitro fertilization (IVF) benefits under the City's health plan.

On behalf of Mr. Briskin and Mr. Maggipinto, I am filing the attached charge of discrimination with the Commission. My clients assert class-based discrimination charges under Title VII of the Civil Rights Act, the New York State Human Rights Law, and the New York City Human Rights Law. They allege that the City of New York's denial of IVF benefits to gay male employees constitutes unlawful sex and sexual orientation discrimination. We request that the Commission thoroughly investigate this charge on a systemic basis and find that the City's policy is unlawful.

Please do not hesitate to let me know if you have any questions.

Sincerely,

/ s / Peter Romer-Friedman

Peter Romer-Friedman

Gupta Wessler PLLC
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EEOC Form 5 (5/01)

CHARGE OF DISCRIMINATION

This form is affected by the Privacy Act of 1974 See enclosed Privacy Act Statement and other information before completing this form

Charge Presented To: Agency(es) Charge No(s):

[ ] FEPA
[X] EEOC

New York City Commission on Civil Rights, New York State Division of Human Rights and EEOC

State or local Agency, if any

Name *(indicate Mr , Ms , Mrs)*	Home Phone *(Incl Area Code)*	Date of Birth
Corey Briskin and Nicholas Maggipinto	**202-888-1741 (Counsel, Gupta Wessler PLLC contact)**	[redacted]

Street Address	City State and Z P Code
[redacted]	**Brooklyn, NY** [redacted]

Named s the Emp oyer, Labor Organ zat on, Emp oyment Agency, Apprent cesh p Comm ttee, or State or Loca Government Agency That I Be eve D scr m nated Aga nst Me or Others. (*If more than two list under PARTICULARS below*)

Name	No Employees Members	Phone No *(Include Area Code)*
City of New York	**325,000**	**(212) 356-1000**

Street Address	City State and Z P Code
100 Church Street.	**New York, NY 10007**

Name	No Employees Members	Phone No *(Include Area Code)*

Street Address	City State and Z P Code

D SCR M NAT ON BASED ON *(Check appropriate box(es))*

[ ] RACE [ ] COLOR [X] SEX [ ] REL G ON [ ] NAT ONAL OR G N
[ ] RETAL AT ON [ ] AGE [ ] D SAB L TY [X] OTHER *(Specify below)*

Sexual Orientation

DATE(S) D SCR M NAT ON TOOK PLACE

Earliest	Latest
2017	**Present**

[X] CONT NU NG ACT ON

THE PART CULARS ARE *(If additional paper is needed, attach extra sheet(s)):*

See the attached particulars.

want this charge filed with both the EEOC and the State or local Agency if any will advise the agencies if change my address or phone number and will cooperate fully with them in the processing of my charge in accordance with their procedures

I dec are under pena ty of perjury that the above s true and correct.

April 12, 2022
Date

[redacted]

April 12, 2022

NOTARY *When necessary for State and Local Agency Requirements*

I swear or aff rm that I have read the above charge and that t s true to the best of my know edge, nformat on and be ef.

S GNATURE OF COMPLA NANT

SUBSCR BED AND SWORN TO BEFORE ME TH S DATE
(*month, day, year*)

PRIVACY ACT STATEMENT: Under the Privacy Act of 1974, Pub. Law 93-579, authority to request personal data and its uses are:

1. FORM NUMBER/TITLE/DATE. EEOC Form 5, Charge of Discrimination (5/01).

2. AUTHORITY. 42 U.S.C. 2000e-5(b), 29 U.S.C. 211, 29 U.S.C. 626, 42 U.S.C. 12117.

3. PRINCIPAL PURPOSES. The purposes of a charge, taken on this form or otherwise reduced to writing (whether later recorded on this form or not) are, as applicable under the EEOC anti-discrimination statutes (EEOC statutes), to preserve private suit rights under the EEOC statutes, to invoke the EEOC's jurisdiction and, where dual-filing or referral arrangements exist, to begin state or local proceedings.

4. ROUTINE USES. This form is used to provide facts that may establish the existence of matters covered by the EEOC statutes (and as applicable, other federal, state or local laws). Information given will be used by staff to guide its mediation and investigation efforts and, as applicable, to determine, conciliate and litigate claims of unlawful discrimination. This form may be presented to or disclosed to other federal, state or local agencies as appropriate or necessary in carrying out EEOC's functions. A copy of this charge will ordinarily be sent to the respondent organization against which the charge is made.

5. WHETHER DISCLOSURE IS MANDATORY; EFFECT OF NOT GIVING INFORMATION. Charges must be reduced to writing and should identify the charging and responding parties and the actions or policies complained of. Without a written charge, EEOC will ordinarily not act on the complaint. Charges under Title VII or the ADA must be sworn to or affirmed (either by using this form or by presenting a notarized statement or unsworn declaration under penalty of perjury); charges under the ADEA should ordinarily be signed. Charges may be clarified or amplified later by amendment. It is not mandatory that this form be used to make a charge.

NOTICE OF RIGHT TO REQUEST SUBSTANTIAL WEIGHT REVIEW

Charges filed at a state or local Fair Employment Practices Agency (FEPA) that dual-files charges with EEOC will ordinarily be handled first by the FEPA. Some charges filed at EEOC may also be first handled by a FEPA under worksharing agreements. You will be told which agency will handle your charge. When the FEPA is the first to handle the charge, it will notify you of its final resolution of the matter. Then, if you wish EEOC to give Substantial Weight Review to the FEPA's final findings, you must ask us in writing to do so within 15 days of your receipt of its findings. Otherwise, we will ordinarily adopt the FEPA's finding and close our file on the charge.

NOTICE OF NON-RETALIATION REQUIREMENTS

Please **notify** EEOC or the state or local agency where you filed your charge **if retaliation is taken against you or others** who oppose discrimination or cooperate in any investigation or lawsuit concerning this charge. Under Section 704(a) of Title VII, Section 4(d) of the ADEA, and Section 503(a) of the ADA, it is unlawful for an *employer* to discriminate against present or former employees or job applicants, for an *employment agency* to discriminate against anyone, or for a *union* to discriminate against its members or membership applicants, because they have opposed any practice made unlawful by the statutes, or because they have made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under the laws. The Equal Pay Act has similar provisions and Section 503(b) of the ADA prohibits coercion, intimidation, threats or interference with anyone for exercising or enjoying, or aiding or encouraging others in their exercise or enjoyment of, rights under the Act.

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

COREY BRISKIN AND NICHOLAS MAGGIPINTO, on behalf of themselves and similarly situated persons, *Complainants,* v. **CITY OF NEW YORK**, *Respondent.*	**CLASS ACTION DISCRIMINATION CHARGE (PARTICULARS)**

INTRODUCTION

The City of New York offers insurance coverage for in vitro fertilization (IVF) for eligible employees and their partners, enabling those who cannot conceive a child through traditional means to build a family. But the City and its insurance company categorically exclude gay men[1] and same-sex male couples from receiving those benefits.

The City does this by limiting IVF coverage to employees or spouses who are "infertile" and then defining infertility as an inability to have a child through male-female sexual intercourse or intrauterine insemination. That means that a straight employee who is unable to conceive with their partner can qualify as "infertile" and receive IVF coverage. So can a lesbian employee unable to conceive with her partner (using a sperm donor). But gay men, although equally incapable of conceiving a child without IVF, are denied coverage entirely. In this way, the City's policy breathes life into the outdated stereotype that gay men are not fit to be parents.

Corey Briskin and Nicholas Maggipinto are among the many gay men who have been denied IVF coverage under the City's policy. A married couple, Mr. Briskin and Mr. Maggipinto are eager to start a family. But IVF is very expensive—and for Mr. Briskin and Mr. Maggipinto, like many others, prohibitively so. The insurance coverage that the City denies them, in other words, would bridge the gap that has prevented them from expanding their family. And if they were a different sex or sexual orientation, the City's policy would enable them to start their family.

For that reason, the City's policy is unlawful. The Supreme Court has made clear that discriminating in the terms and conditions of employment on the basis of sex and sexual orientation, as the City's policy does, violates Title VII of the Civil Rights Act. *Bostock v. Clayton Cnty*, 140 S. Ct. 1731, 1737 (2020); *City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978). New York State and City law do the same.

Mr. Briskin and Mr. Maggipinto have repeatedly asked the City of New York to treat them equally and to modify its policy to make it inclusive for *all* City employees. Because the City has repeatedly refused to guarantee them equality, Mr. Briskin and Mr. Maggipinto are bringing this class action charge to realize their aspiration of building a family and demand equal rights for themselves and all other workers or partners of workers subject to the City's discriminatory policy.

[1] The use of the terms "gay men" and "lesbians" in this charge refers to cisgender gay men and cisgender lesbians, respectively.

Mr. Briskin and Mr. Maggipinto are represented by Peter Romer-Friedman and Robert D. Friedman of Gupta Wessler PLLC and Joseph Wardenski of Wardenski P.C. Their contact information is provided below.

BACKGROUND

I. IVF is indispensable for same-sex couples seeking to build their families.

Same-sex couples face unique challenges in building their families because they cannot conceive through sexual intercourse. Thankfully, the modern marvel of assisted reproductive technologies has made the dream of building a family one step closer to reality for many LGBTQ+ couples.

IVF is the most common form of assisted reproductive technology. The IVF process begins with medication intended to stimulate the production of ova in a female. Those ova, which may be supplied by an "egg donor" or by the female seeking to build her family, are then removed and exposed to or injected with sperm. If this fertilization process is successful, the resulting embryo is implanted into the uterus of the female who will carry the pregnancy. That female may be the female seeking to build her family, a surrogate, or less commonly, an egg donor who also serves as a surrogate. IVF is a notably effective medical treatment for individuals and couples—whether gay or otherwise—who cannot achieve pregnancy through intercourse. IVF results in a live birth in 54.5% of cases in which intended parents are afforded up to three IVF cycles.

But IVF is notoriously expensive and creates a substantial financial burden that stands in the way of people who are unable to conceive through male-female sexual intercourse from ever having a child of their own. A single IVF cycle can cost tens of thousands of dollars. *See* Ex. 1 (providing examples of different pricing plans). And because success is not guaranteed, conceiving a child through IVF can require multiple cycles and, it follows, multiple times the cost.

Same-sex male couples are particularly reliant on IVF to conceive children because neither partner can produce ova. Unlike different-sex couples, same-sex female couples, and single females, there is no less burdensome option available to gay men and same-sex male couples seeking to conceive than IVF.

The indispensable role that fertility benefits, including coverage for IVF, play in the family-planning processes of same-sex couples is reflected in the recent actions of New York State's Department of Financial Services (DFS) and the New York State legislature. DFS conducted a study to determine whether to mandate that insurers cover IVF, and it concluded that there would be substantial benefits for same-sex couples.[2] The state legislature subsequently amended the law to mandate fertility coverage for New York insureds—regardless of sexual orientation—who are covered by most healthcare plans.[3] Additionally, New York recently amended its laws to legalize paid surrogacy with the specific intent of expanding opportunities for same-sex couples to avail themselves of IVF benefits for their family-building goals.[4] And addressing discrimination in this

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[2] Department of Financial Services, Report on In-Vitro Fertilization and Fertilization Preservation Coverage at 1 (Feb. 27, 2019), https://perma.cc/D59Q-6D39.

[3] Department of Financial Services, *IVF and Fertility Preservation Law Q&A Guidance*, https://perma.cc/7KYY-RU4B.

[4] New York State Governor, Governor Cuomo Announces Gestational Surrogacy Now Legal in New York State (Feb. 16, 2021), https://perma.cc/E59W-BYDQ ("'For far too long, LGBTQ+ New Yorkers and New Yorkers struggling with fertility were denied the opportunity to start a family because

very context, DFS expressly directed insurance providers "to provide immediate coverage of diagnostic and treatment services, including prescription drugs, for the diagnosis and treatment of infertility for individuals who are unable to conceive *due to their sexual orientation or gender identity* and are covered under . . . group health insurance policies and contracts."[5] In doing so, DFS followed the lead of the legislature, which had already enacted a non-discrimination provision prohibiting health insurers from "discriminat[ing] [in providing coverage for infertility services] based on an insured's . . . personal characteristics, including age, sex, sexual orientation, marital status or gender identity."[6]

II. The City applied its unlawful policy to deny Mr. Briskin and Mr. Maggipinto access to IVF.

Mr. Briskin began working as an Assistant District Attorney at the New York County District Attorney's Office in 2017. He resigned his appointment in February 2022 to pursue a new career opportunity. He and Mr. Maggipinto were married in 2016. Mr. Briskin, as a covered employee, and Mr. Maggipinto, as a covered spouse of an employee, have had healthcare coverage through the City's Comprehensive Benefits Plan underwritten by EmblemHealth/GHI.[7]

In 2017, Mr. Briskin and Mr. Maggipinto decided to expand their family. To do so, they needed to use IVF. Because of the substantial expense of IVF—too much for Mr. Briskin and Mr. Maggipinto to afford on their own—they turned to their insurance coverage.

But they quickly learned that the insurance coverage they obtained through Mr. Briskin's employment with the City does not provide IVF benefits for gay men. Under the CBP/GHI policy, a covered person is only eligible for IVF services until they are deemed to have "infertility."[8] Ex. 3 at 95. "Infertility is defined as the inability to conceive after twelve (12) months of unprotected intercourse." *Id.* Although "intercourse" is undefined, the City and its insurers have interpreted it to mean intercourse between a man and a female, thereby making it impossible for Mr. Briskin and Mr. Maggipinto to satisfy the definition. The City and its insurer also deem a female without a male partner to be "infertile" if she unsuccessfully attempts 12 cycles of intrauterine insemination over a period of 12 months. But under the City's health plan there is no equivalent method for allowing gay men to prove the obvious: that they cannot conceive through intercourse with their male partner or through intrauterine insemination.

Rather, gay men like Mr. Briskin and Mr. Maggipinto can never obtain IVF benefits that are made available to different-sex couples, lesbian couples, and single females covered under their same health plan. In this way, gay men are not merely the only type of plan participants categorically excluded from IVF benefits; they are also, in effect, the only plan participants excluded from any fertility benefits *at all*, as IVF is the only ART method realistically available to

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of arbitrary and archaic laws . . . ,' Governor Cuomo said.").

[5] *Health Insurance Coverage of Infertility Treatments Regardless of Sexual Orientation or Gender Identity* at 1 (Feb. 23, 2021), https://perma.cc/A7MV-K7FE; Ex. 3, Department of Financial Services, Insurance Circular Letter No. 3 (2021);

[6] N.Y. Ins. Law §§ 3221(k)(6)(C)(viii), 4303(s)(3)(H).

[7] Notwithstanding Mr. Briskin's resignation from employment, he remains insured under the City's GHI/CBP health insurance plan through April 2022 and presently intends to remain covered under such plan beyond April 2022 in accordance with his right to do so under COBRA (29 U.S.C. § 1161(a)).

[8] They must also go through four months of fertility services less invasive than IVF, but for gay men, no such services exist.

gay men.

On June 8, 2021, approximately three months after DFS directed health insurers to provide fertility benefits, including IVF, without regard to the sex or sexual orientation, Mr. Briskin contacted the City's Office of Labor Relations and a human resources representative at the New York County District Attorney's Office to request coverage for specific IVF services. Mr. Briskin identified the insurance procedural codes for the services his doctor explained were necessary. But OLR said that Mr. Briskin and Mr. Maggipinto were not eligible for those services and denied his request for the City to cover them.

On July 12, 2021, Mr. Briskin contacted the New York City Corporation Counsel, the agency that represents the City in legal disputes, to express his concern that the City had denied his request for IVF services and that the City had a policy regarding IVF benefits that discriminates against gay men based on sex and sexual orientation. He asked the Corporation Counsel to change the City's IVF policy to comply with anti-discrimination laws. This request was denied, too.

The City's discriminatory policy has forced Mr. Briskin and Mr. Maggipinto to put their lives on hold and has prevented them from building the family they desire—only because of their sex and sexual orientation. It has caused them to be denied employee benefits that are potentially worth hundreds of thousands of dollars. The City's discrimination has caused each of them emotional harm. Both have sought out the help of medical professionals to attempt to manage the impact of being denied necessary medical services because of their sex and sexual orientation and the emotional harm they have suffered—and continue to suffer—from being unable to have children that they are otherwise qualified and entitled to have. Meanwhile, each year that they have delayed starting their family, the cost of IVF has risen.

VIOLATIONS OF FEDERAL, STATE, AND CITY LAW

The City's policy discriminates against Mr. Briskin and Mr. Maggipinto, and all similarly situated individuals, based on sex and sexual orientation in violation of Title VII, the New York State Human Rights Law, and the New York City Human Rights Law. *See* 42 U.S.C. § 2000e-2(a); N.Y. Exec. Law 296(1)(a); N.Y.C. Admin Code § 8-107(1)(a).

If Mr. Briskin and Mr. Maggipinto—and scores of other gay men covered under City-sponsored health insurance policies—were of a different sex (female) or sexual orientation (heterosexual), but unable to conceive a child with their partner or through an accepted alternative like IUI, the policy would deem them "infertile" and they would be entitled to coverage for IVF. But the interpretation and enforcement of the "infertility" barrier to exclude gay men unable to conceive creates an insurmountable obstacle that exists only for them and not for other similarly situated individuals. This amounts to unlawful sex- and sexual orientation-based classifications, *see City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978); *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020); *Obergefell v. Hodges*, 576 U.S. 644, 681 (2015), and revives the misconception, grounded in uninformed and biased stereotypes, that same-sex male couples are not fit to build families while different-sex and same-sex female couples are fit to do so.

The result is that gay men are treated differently than others in the same position. To take just one example, a straight female who cannot produce ova can nonetheless receive insurance coverage for the process of extracting ova from a donor; gay men like Mr. Briskin and Maggipinto, though equally unable to produce ova, cannot. There is no valid justification for this discrimination.

Furthermore, the City's policy has a significant disparate impact on gay men like Mr. Briskin and Mr. Maggipinto, and there is no legitimate non-discriminatory reason for the City's policy of only denying IVF benefits to gay men. Indeed, since 2017, New York State's DFS has recognized that there is no basis to deny IVF coverage to anyone based on sexual orientation, but that is exactly what the City's policy does.[9] And for whatever ambiguity the City might have claimed to rely upon for its prior unlawful denials of coverage to Mr. Briskin and Mr. Maggipinto, the New York State legislature's recent amendments to the state's insurance law expressly prohibited denial of IVF coverage based on sex or sexual orientation, which is exactly what the City did in denying Mr. Briskin's request to OLR for assistance in obtaining coverage and in refusing Mr. Briskin's request to Corporation Counsel to change the City's discriminatory policy.

It is no answer for the City to shift blame to its group health insurance administrator. To be sure, GHI is also violating Mr. Briskin and Mr. Maggipinto's rights as an agent of the City and, in its own right, as a health insurer subject to federal and state nondiscrimination protections. But the City cannot choose to make available to employees only insurance coverage that discriminates on the basis of sex and sexual orientation, only to then claim innocence and point the finger at the insurer, any more than it can choose to make available only insurance that provides benefits to people of a certain race or other protected characteristic.

This charge is intended to exhaust all potential individual and class-based disparate treatment and disparate impact claims under Title VII, the NYSHRL, and the NYCHRL regarding the City's practice of sex and sexual orientation discrimination related to its IVF policy on behalf of all current and former City employees for the earliest timely period under federal, state, and local law through the present (the Class). All of the violations alleged herein are continuing violations, and all of the claims are brought on behalf of the Class as defined above. These charges are intended to piggyback on any prior charges that allege discrimination related to the City's IVF policy.

This charge is filed within the relevant time limits for filing charges under Title VII, the NYSHRL, and the NYCHRL. The City's policy has operated to continuously deny Mr. Briskin and Mr. Maggipinto the IVF benefits they need and to which they are entitled. This charge is also filed within 300 days of Mr. Briskin's most recent formal request for services.

CONCLUSION

Because the City's policy unlawfully discriminates against Mr. Briskin and Mr. Maggipinto, the Commission should issue a finding that the City's policy constitutes unlawful sex and sexual orientation discrimination and order any other relief it deems appropriate.

Dated: April 12, 2022

[9] Department of Financial Services, Insurance Circular Letter No. 7 (Apr. 19, 2017), https://perma.cc/6X6G-R65G.

CONTACT INFORMATION OF COUNSEL

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Exhibit 1

Surrogacy & Egg Donation
PROGRAM & PRICING

Circle Surrogacy & Egg Donation

Circle Surrogacy & Egg Donation is the leading surrogacy agency because we always put our Intended Parents' needs first, with two primary goals: **success and cost security**.

We are the only agency to offer an **all-inclusive cost program**, so intended parents can plan financially for their journey from day one.

JOURNEY PROTECTION GUARANTEE PROGRAM

Our Journey Protection Guarantee offers Intended Parents:

- An all-inclusive cost that **covers unlimited transfers and any complications** that may arise during your journey
- **100% refund of our agency fee** if you have no embryos remaining and do not bring home a baby
- **No surprise costs** or invoices

Cost for Surrogacy & Egg Donation: $165,250

Our Journey Protection Guarantee Program includes fixed costs on the following:

Professional Fees
- Matching
- Screening
- Legal
- Accounting
- Medical Billing
- Re-matches

Carrier and Egg Donor
- Base Fees
- Travel
- Bedrest
- Local Monitoring
- Contingencies (e.g. c-section)

Pregnancy, Labor & Delivery Insurance
- Premium/GC Payment
- Maternity Insurance
- Complications
- Life Insurance
- Insurance Defense
- Back-up Policy

Cost associated with your IVF clinic (embryo creation, screening, transfers, medications, etc) are not included in Circle's costs.

Circle Surrogacy is able to offer an all-inclusive cost program because we are the most successful surrogacy agency in the country, helping to **bring over 2,500 babies into the world** since 1995.

Over the past 500+ surrogacy journeys, we're proud to share the **success rates** for surrogacy journeys when intended parents completed their journey.

99.3%
SUCCESS RATE
See website for details.

Surrogacy & Egg Donation COST AND PAYMENT OVERVIEW

JOURNEY PROTECTION GUARANTEE PROGRAM

SERVICES PROVIDED	COST	AMOUNT DUE
FIRST PAYMENT – AT SIGN ON		**$45,000**
Surrogacy Program Agency Fee	$31,500	*We'll refund 100% of our agency fee if you have no embryos remaining and you do not bring home a baby.*
Egg Donor Program Agency Fee	$8,000	
Discount for 1st Time Circle Egg Donor	($3,000)	
Advance on Third-Party Expenses	$8,500	
SECOND PAYMENT – AT EGG DONOR MATCH		**$24,500**
Egg Donor Expenses at Match (with $9,000 Egg Donor Base Fee)	$14,000	
Egg Donor legal screening and support	$2,000	
Journey Protection Guarantee	$8,500	
THIRD PAYMENT – AT SURROGATE MATCH		**$95,750**
Surrogate Expenses at Match (with $35,000 Surrogate Base Fee)	$57,500	
Surrogate legal screening and support	$9,750	
Intended Parent Legal Rights	$8,500	
Insurance Expenses	$20,000	
TOTAL COST FOR JOURNEY PROTECTION GUARANTEE PROGRAM		**$165,250**

Potential variable costs for your surrogacy and egg donation journey, based on your preferences

Additional Surrogate Fee based on location/experience ($5,000-$15,000)
Additional Egg Donor Fee (dependent on donor experience)

Additional Program Options

Multiple Embryo Transfer Program (assuming twin pregnancy)	$25,000
VIP Program	$30,000
Newborn ($100,000 of medical bills)	$10,000

Expenses Not Covered in the Circle JPG Program

IVF Expenses: for creation of embryos, medications, transfers OR	$29,900-$49,900
with existing embryos	$7,000-$15,000
Newborn Expenses (estimate of cash pay for single child)	$4,000-$10,000
Additional Intended Parent requests, such as pumping breast milk	varies

Financial Agreement

RMACT In-House Egg Donor, Gestational Carrier, Surrogacy Plan with PGT-A

Donor Fees	$16,281.00

Donor fees include: psychological testing and evaluation, all physician and nursing visits, checklist blood work and cultures, urine drug screening, FDA screening blood work, genetic testing, consultation with genetic counselor, medical insurance to cover the donor's cycle, and donor compensation ($8,000).

***If your donor's cycle is cancelled prior to oocyte retrieval, and the donor has been on medication 5 days or less, you are responsible for compensating her $750.00 for her time and effort. If the donor has been on medication for 6 days or more, you are responsible for compensating her $1,500.00. You are also responsible for the donor medications that have already been used ($4,200.00). ***

Gestational Carrier Fees	$2,819.00

Gestational Carrier fees include: physician consultation, uterine evaluation, checklist blood work for both carrier and partner (if applicable), FDA screening blood work. This fee is subject to change if psychological testing has not been completed by the surrogacy agency.

Surrogacy Plan with Preimplantation Genetic Screening (PGT-A)	$27,650.00

The Surrogacy Plan includes: cycle medication for the oocyte donor and gestational carrier, anesthesia for the retrieval of oocytes, oocyte donor cycle monitoring completed at RMACT, oocyte retrieval, embryology laboratory charges, PGT-A of up to 10 embryos, cryopreservation of embryos, cycle monitoring for the last ultrasound and blood tests prior to embryo transfer, embryo transfer into the gestational carrier, and the first year of embryo and specimen storage. In the event the initial frozen embryo transfer is unsuccessful, an additional frozen embryo transfer is included in hopes of a successful pregnancy. The additional frozen embryo transfer will not be offered following a successful pregnancy resulting in a live birth.

The Surrogacy Plan is $24,000.00. PGT-A Testing on 10 embryos is $3,650.00

Total Cost:	$46,750.00

This includes charges for; oocyte donors medical screening, gestational carrier medical screening, oocyte retrieval, PGT-A testing on 10 embryos, frozen embryo transfer(s) to gestational carrier.

The following services are not covered

- Intended Parent(s) medical screening
- Gestational carrier compensation or legal fees
- Medical treatment associated with an unsuccessful cycle (treatment for miscarriage, ectopic or biochemical pregnancy)
- Pregnancy related treatment and pregnancy medications
- Medical services for the gestational carrier
- Preimplantation Genetic Diagnosis (PGD)
- Physician, Genetic, Nutrition consultations
- Cycle monitoring or outside monitoring for the gestational carrier other than what is specified above
- Gestational carrier psychological evaluation and testing ($1,000)
- Mock cycle or ERA testing for the gestational carrier
- Oocyte cryopreservation ($1,720); TESA/MESA services
- Storage of embryos or specimen beyond one year ($50.00 monthly each)
- In House Known Donor consultation ($125) or Skype ($200)

_____ _____ _____

Patient Name (Please Print) Partner Name (if applicable) (Please Print) Date

Financial Agreement
RMACT In-House Egg Donor, Gestational Carrier Surrogacy Plan with PGT-A

By initialing below, I acknowledge and understand

_____ **A $3,000.00 program deposit is required to access donor profiles and constitutes an agreement to work with RMACT. This deposit is not an additional charge and will be subtracted from the total cost of any procedures or services received from RMACT.**

_____ **Within 3 days of matching with an RMACT donor, your donor medical screening fee ($13,281.00), 75% of the Surrogacy Plan ($18,000.00) and your PGS testing payment ($3,650.00) is due.**

_____ **Payment for the Gestational Carrier Fee is due prior to the screening visit. 25% of The Surrogacy Plan ($6,000.00) is due once the Gestational Carrier has legal clearance.**

_____ **On occasion egg donors and gestational carriers do not meet medical criteria. If your donor or gestational carrier is not clinically cleared to continue, you will be charged fee for service for the treatment already provided.**

_____ **If the donor's cycle is cancelled prior to oocyte retrieval and the donor has been on medication 5 days or less, I am responsible for compensating her $750.00 for her time and effort. If the donor has been on medication for 6 days or more, I am responsible for compensating her $1,500.00. I am also responsible for the donor's medications that have already been used ($4,200.00)**

_____ **I have received, read and understood The Surrogacy Plan with Select PGT-A overview provided.**

_____ **If more than 10 embryos are produced it is an additional $365 per embryo to have PGT-A testing performed. I understand any embryo beyond the 10 will be cryopreserved. If I do not complete the credit card authorization to prepay in advance for beyond the 10 embryos I will be subject to additional fees to thaw ($300), and re-freeze ($1,200) my remaining embryos**

_____ **In the event a tested embryo is transferred, and a live birth occurs, this plan is considered complete regardless of the number of embryos tested.**

_____ **After the first year, storage of embryos, and specimen will be billed to me at $50 a month, which is ($600.00 each) via Embryo Options. It is my responsibility to register and verify if I have specimen or embryos left after a cycle is complete. If I no longer want my embryos or specimen stored at RMACT I must have them transferred out or provide a signed and notarized dispose consent to cease billing. I can access this form via Embryo Options.**

_____ **Cancelled services that have been pre-paid in advance will be refunded less any balance owed. Refunds will be reimbursed by the method they were paid and can take up to 14 business days to process.**

_____ **Payment on all outstanding balances is required prior to the start of treatment. I understand that RMACT accepts cash, check, Discover, MasterCard, Amex and Visa.**

_____ **I understand the In-House Donor, Gestational Carrier, Surrogacy Plan with PGT-A testing does not participate with any insurance plans. I understand this is an out of pocket cost, and my insurance will not be billed for any services covered under the In-House Donor, Gestational Carrier, Surrogacy Plan with PGT-A testing.**

_____ **All fees are subject to change**

At every step of the way your Insurance and Billing Advocates are here to help you, answer your questions, and provide support. We wish you the best.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date
_____	_____	_____
Partner Name (if applicable) (Please Print)	Partner Signature	Date
_____	_____	
Financial Services Representative (Please Print)	Representative Signature	Date

Financial Agreement
Agency Donor, Gestational Carrier, Surrogacy Plan with PGT-A

Donor Fees	$2,830.00

Donor fees include: physician consultation and scan, infectious disease and FDA bloodwork, drug screening, genetic testing and consultation. This fee is subject to change if psychological testing has not been completed by the donor's agency.

Gestational Carrier Fees	$2,819.00

Gestational Carrier fees include: physician consultation, uterine evaluation, checklist blood work for both carrier and partner (if applicable), FDA screening blood work. This fee is subject to change if psychological testing has not been completed by the surrogacy agency.

Surrogacy Plan with Preimplantation Genetic Screening (PGT-A)	$27,650.00

The Surrogacy Plan includes: cycle medication for the oocyte donor and gestational carrier, anesthesia for the retrieval of oocytes, two days of oocyte donor cycle monitoring completed at RMACT, oocyte retrieval, embryology laboratory charges, PGT-A of up to 10 embryos, cryopreservation of embryos, cycle monitoring for the last ultrasound and blood tests prior to embryo transfer, embryo transfer into the gestational carrier, and the first year of embryo and specimen storage. In the event the initial frozen embryo transfer is unsuccessful, an additional frozen embryo transfer is included in hopes of a successful pregnancy. The additional frozen embryo transfer will not be offered following a successful pregnancy resulting in a live birth.

The Surrogacy Plan is $24,000.00. PGT-A Testing on 10 embryos is $3,650.00

Total Cost:	$33,299.00

This includes charges for the egg (oocyte) donor, gestational carrier and the fees associated with The Surrogacy Plan with PGT-A as outlined above.

The following services are not covered

- Intended Parent(s) medical screening
- Gestational carrier compensation or legal fees
- Medical treatment associated with an unsuccessful cycle (treatment for miscarriage, ectopic or biochemical pregnancy)
- Pregnancy related treatment and pregnancy medications
- Medical services for the gestational carrier
- Preimplantation Genetic Diagnosis (PGD)
- Physician, Genetic, Nutrition consultations
- Donor compensation, legal, travel expenses
- Cycle monitoring or outside monitoring for the egg donor and gestational carrier other than what is specified above
- Gestational carrier psychological evaluation and testing ($1,000) Egg donor psychological evaluation ($350)
- Known Donor Psychological evaluation ($1,000)
- Mock cycle or ERA testing for the gestational carrier
- Oocyte cryopreservation ($1,720); TESA/MESA services
- Storage of embryos or sperm beyond one year ($50.00 monthly)

_____ _____ _____

Patient Name (Please Print) Partner Name (if applicable) (Please Print) Date

Financial Agreement
Agency Donor, Gestational Carrier
Surrogacy Plan with PGT-A

By initialing below, I acknowledge and understand

_____ **Payment for the Donor Fees is due prior to the screening visit. 75% of The Surrogacy Plan ($18,000.00) and your PGTA testing payment ($3,650.00) is due once your donor is medially cleared to proceed.**

_____ **Payment for the Gestational Carrier Fee is due prior to the screening visit. 25% of The Surrogacy Plan ($6,000.00) is due once the Gestational Carrier has been legally cleared.**

_____ **If my agency donor is not clinically cleared or her cycle is cancelled I will be responsible to pay for services rendered.**

_____ **If my gestational carrier is not clinically cleared or her cycle is cancelled I will be responsible to pay for services rendered.**

_____ **In the event a tested embryo is transferred, and a live birth occurs, this plan is considered complete regardless of the number of embryos tested.**

_____ **If more than 10 embryos are produced it is an additional $365 per embryo to have PGT-A testing performed. I understand any embryo beyond the 10 will be cryopreserved. If I do not complete the credit card authorization to prepay in advance for beyond the 10 embryos I will be subject to additional fees to thaw ($300), and re-freeze ($1,200) my remaining embryos**

_____ **After the first year, storage of embryos, and specimen will be billed to me at $50 a month, which is ($600.00 each) via Embryo Options. It is my responsibility to register and verify if I have specimen or embryos left after a cycle is complete. If I no longer want my embryos or specimen stored at RMACT I must have them transferred out or provide a signed and notarized dispose consent to cease billing. I can access this form via Embryo Options.**

_____ **Cancelled services that have been pre-paid in advance will be refunded less any balance owed. Refunds will be reimbursed by the method they were paid and can take up to 14 business days to process.**

_____ **Payment on all outstanding balances is required prior to the start of treatment. I understand that RMACT accepts cash, check, Discover, MasterCard, Amex and Visa.**

_____ **I understand the Agency Donor, Gestational Carrier, Surrogacy Plan with PGT-A testing does not participate with any insurance plans. I understand this is an out of pocket cost, and my insurance will not be billed for any services covered under the Agency Donor, Gestational Carrier, Surrogacy Plan with PGT-A testing.**

_____ **That I have received, read and understand The Surrogacy Plan with PGTA overview provided.**

_____ **All fees are subject to change**

At every step of the way your Insurance and Billing Advocates are here to help you, answer your questions, and provide support. We wish you the best.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date
_____	_____	_____
Partner Name (if applicable) (Please Print)	Partner Signature	Date
_____	_____	
Financial Services Representative (Please Print)	Representative Signature	Date

Initial Carrier and Egg Donor Program Costs

Gestational Carrier Program Professional Fees	**$22,750**
First installment agency fee (non-refundable upon execution of Agreement for Services)	$13,000*
Second installment agency fee (non-refundable upon execution of Carrier Agreement)	$8,500*
Fee for unlimited Gestational Carrier rematches	$2,500*
Office expenses	$750*
Discount for signing up within three months of consultation	($2,000)

Gestational Carrier Program Legal, Screening, and Support	**$14,500**
Unlimited Social Worker screenings of Carrier and partner (including standard personality testing)	$2,000*
Criminal history inquiry fees for carrier and intended parents	$300*
Licensed Clinical Social Worker's fees for unlimited Carrier support	$3,500*
Trust administration	$2,000*
Intended Parents' attorney's fees for carrier agreement (includes agreements for rematches)	$2,500*
Carrier's independent attorney's fees (includes Carrier representation for rematches)	$1,200*
Coordination of local monitoring	$500
Advance on travel for Carrier screening (e.g., airfare, hotel, rental, childcare, lost wages, per diem, etc.)	$2,500

Egg Donor Program Professional Fees	**$9,000**
Non-refundable Egg Donor agency fee	$7,500*
Fee for unlimited Egg Donor rematches, including all parties' representation for agreement	$1,500*

Egg Donor Program Legal, Screening, and Support	**$5,350**
Intended Parents' attorney's fees for Egg Donor agreement (includes agreements for rematches)	$1,250*
Egg Donor's independent attorney's fees (includes donor representation for rematches)	$600*
Egg Donor screening and testing fees (including standard personality testing)	$1,000*
Advance on travel for Egg Donor screening (e.g., airfare hotel, rental, per diem, etc.)	$2,500

Amount Due at Signing (if within three months of consult)	**$49,600**

Amount Due at Signing (three months after consult)	**$51,600**

*Denotes fixed costs, not subject to change once contract is signed

Egg Donor and Carrier Costs

Egg Donor Matching Costs	$13,500
Payment to Egg Donor	$9,000
Advance on travel for Egg Donor retrieval (e.g., airfare, hotel, rental, per diem, etc.)	$2,500
Donor's local monitoring (if needed)	$2,000

Carrier Matching Costs	$50,750
Estimated fees for legal proceedings	$7,000
Carrier reimbursements	$30,000
Transfer payment (per transfer)	$750
Maternity clothing (singleton pregnancy)	$500
Estimated monthly expenses (e.g., mileage, childcare, prenatal vitamins, etc.—15 x $200)	$3,000
Advance on average pregnancy and delivery expenses for one child services, including bedrest, lost wages, childcare, housekeeping, and misc. fees paid to Carrier for a C-section, amino, CVS, D&C, cerclage, termination or selective reduction, mock cycle, cancelled cycle, both-birth recovery, and/or loss of reproductive organ[1]	$5,000
Advance on travel for Carrier transfer (e.g., airfare, hotel, rental, childcare, lost wages, per diem, etc.)	$2,500
Carrier's local monitoring (likely needed)	$2,000

[1] These costs represent an average cost for a single pregnancy. The fees are negotiated as part of the Carrier Agreement. Potential charges include: Carrier's estimated bedrest cap for lost wages, childcare, and/or housekeeping ($5,400) and housekeeping for last month of pregnancy ($400). Additionally, Carriers would receive fees for the following: C-section ($2,500), amniocentesis, CVS, D&C or cerclage ($500 per procedure), termination or selective reduction procedure ($1,000), mock cycle ($250), cancelled cycle ($500), and loss of reproductive organ ($3,000).

IVF Clinic's Costs

Single Retrieval and All Transfers[2]	Unlimited Retrieval and Transfers[2]
Includes: • Single retrieval of eggs • Creation of embryos • All transfers until a live birth is achieved or embryos depleted • IVF costs • Single Donor screening • Carrier screenings • Consultations • Medications • On location monitoring	Includes: • Unlimited egg retrievals • Creation of embryos • All transfers until a live birth is achieved (effectively a guarantee) • IVF costs • Unlimited Donor screenings • Unlimited Carrier screenings • Consultations • Medications • On location monitoring
Total Cost $29,900	**Total Cost $35,900**

Insurance Options

Fees and Expenses

	Intended Parents Self Pay (No Insurance)	Surrogate with Approved Obamacare Plan (If Available)	Surrogate with Approved Insurance	Intended Parents Purchase Lloyd's Plan
Additional compensation for insured carrier or policy premiums	N/A	$6,000	$5,000	$10,500
Medical billing oversight	N/A	$1,000	$1,000	Included
Insurance management and defense	N/A	$5,000	$5,000	N/A
$350,000 insurance policy on carrier	$435	$435	$435	$435
Unlimited complications insurance for Carrier and Egg Donor	$930	$930	$930	$930
Estimated co-payments, co-insurance, and/or deductibles	$15,000	$6,000	$6,000	$13,500[3] (for singleton)
Lloyds guarantee of carrier insurance coverage, up to $500,000	N/A	$1,500	$1,500	Included
TOTALS	**$16,365**	**$20,865**	**$19,865**	**$25,365**

[2] Excludes PGS testing (estimated cost, $6,000)

[3] Deductible for a twin pregnancy is $30,000

Additional Payments Based on Circumstances

Estimate for Each Additional Transfer or Mock Cycle	$5,050
Transfer payment (paid to Carrier)	$750
Advance on travel for Carrier transfer (e.g., airfare, hotel, rental, childcare, lost wages, etc.)	$2,500
Estimated additional monthly expenses for carrier (3 x $200)	$600
Estimated additional premiums for ACA insurance (for ACA plans only, if available)	$1,200

Estimate for Twin Pregnancy	$12,950
Additional maternity clothing fee	$250
Multiple birth payment to carrier	$5,000
Additional bed rest reimbursements	$4,000
C-section fee (paid to carrier if C-section occurs)	$2,500
Additional post-birth recovery reimbursement (for C-section)	$1,200

Estimate for Additional Egg Retrieval	$13,500
Payment to Egg Donor	$9,000
Advance on travel for Egg Donor retrieval (e.g., airfare, hotel, rental, per diem, etc.)	$2,500
Donor's local monitoring (if needed)	$2,000

Other Potential Expenses	
Additional legal fees for birth order/adoption	$2,000
Additional reimbursement to Experienced Carrier or Carrier in high demand state	$5,000
Additional reimbursement to Carrier for matching with SPAR program or with IPs who need translator	$2,500
Expenses for translator	$3,000
Estimated pumping payments and supplies (if IPs request)	$1,000
Additional Egg Donor payment	$6,000

UNLIMITED GESTATIONAL SURROGACY WITH EGG DONATION
COST ESTIMATES FOR U.S. INTENDED PARENTS [1]

FEES PAID TO AGENCY

Gestational Carrier Related Professional Fees	$23,500.00
First installment agency fee (nonrefundable upon execution of Agreement for Services) (Exhibit 1) **[2]**	$13,000.00
Second installment agency fee (nonrefundable upon execution of Carrier Agreement) (Exhibit 1)	$8,500.00
Fee for unlimited gestational carrier or egg donor rematches (Exhibit 1) **[3]**	$4,000.00
Discount for signing up within 3 months of consultation	-$2,000.00

Gestational Carrier Screening Costs	$700.00
Unlimited psychological testing for Carriers (Exhibit 1)	$600.00
Criminal history inquiry fees (Exhibit 1)	$100.00

Gestational Carrier Compensation and Other Expenses	$29,600.00
Carrier's base fee (9 payments starting with heartbeat ultrasound) (Exhibit 2a)	$25,000.00
Carrier's IVF transfer payments (for completion of each transfer procedure) (Exhibit 2a)	$500.00
Carrier's maternity clothing allowance (paid at 3 months gestational) (Exhibit 2a)	$500.00
Carrier's monthly allowance (in lieu of itemized costs) ($200/month est. for 12 months) (Exhibit 2a)	$2,400.00
Carrier's post-birth recovery (following a vaginal delivery) (Exhibit 2a)	$1,200.00

Egg Donor Compensation, Agency & Legal Fees, Screening and Other Expenses	$16,700.00
Egg Donor's payment (Exhibit 2a)	$8,000.00
Egg Donor agency fee (Exhibit 1)	$6,500.00
Unlimited psychological testing for Egg Donor (Exhibit 1)	$600.00
Egg Donor's independent attorney fees (includes unlimited rematches) (Exhibit 1)	$600.00
Intended Parent(s)'s attorney's fees for Egg Donor Contract (includes unlimited rematches) (Exhibit 1)	$1,000.00

Licensed Clinical Social Worker Support Fees	$3,500.00
Social Worker's flat fee (support & advocacy for carriers) (Exhibit 1)	$3,500.00

Gestational Carrier Related Legal Fees, Expenses and Finalization of Parental Rights	$13,400.00
Carrier's independent attorney's fees (includes unlimited rematches) (Exhibit 1)	$1,200.00
Intended Parent(s)'s attorney fees for Carrier Agreement (incl. unlimited rematches) (Exhibit 1)	$2,500.00
Office expenses (Exhibit 1)	$750.00
Fees for legal proceedings for one child, including fees for Circle legal supervision. (Exhibit 2a)	$7,000.00
Trust Administration (Exhibit 1)	$1,950.00

ESTIMATED TOTAL, FEES PAID TO AGENCY	$87,400.00

IVF OPTIONS [4]
Estimated Total Cost:
$23,800 - $37,750

Intended parents can choose one of the options listed below. The estimates are for packages offered at one of our most popular clinics.

Pay Per Transfer		OR	1 Fresh Embryo Transfer + All Frozen		OR	Unlimited Multiple Embryo Transfers	
For intended parents who choose to pay for each transfer (frozen transfers, if needed, listed on page 3).			Includes egg retrieval, fresh transfer, embryo freezing, and frozen transfers of any remaining frozen embryos.			Includes unlimited fresh egg retrievals and fresh/frozen multiple embryo transfers until you take home your baby.	
Fresh embryo transfer	**$23,800**		**TOTAL**	**$26,800**		**TOTAL**	**$37,750**

All of the estimates above include screening, consultations, medications, and IVF costs.

TRAVEL EXPENSES FOR IVF

Carrier and Donor travel expenses	
Estimated long-distance travel expenses for 1 screening for Carrier and Donor (Exhibit 1)	$4,000
Estimated long-distance travel expenses for 1 transfer for Carrier and Donor (Exhibit 2a)	$4,000
TOTAL	**$8,000**

INSURANCE [5]

Surrogate with her own insurance, ACA plan, or Bridge the Gap	
Additional compensation for surrogate, or premiums for ACA insurance/Bridge the Gap plan – avg.	$5,000
Insurance management and defense [6]	$5,000
Life insurance	$450
Complications insurance	$300
Copayments and deductibles for Carrier's insurance	$3,000
Enrollment fee (for ACA plans only)	$500
TOTAL	**$14,250**

ADDITIONAL COST CONSIDERATIONS [7]

Frozen embryo transfer (if paying per transfer instead of choosing IVF package)	$5,000.00
Carrier's bed rest cap — only at doctor's order	$3,500.00
Carrier's lost wages/child care	$2,500.00
Multiple birth compensation	$5,000.00
Additional maternity clothing allowance for multiples	$250.00
Caesarean Section compensation to carrier (as applicable)	$2,000.00
Compensation to carrier for amniocentesis, CVS, D&C, cerclage (per procedure)	$500.00
Compensation to carrier for termination or selective reduction	$1,000.00
Medical procedure cost for Fetal Reduction (if not covered by insurance)	$2,500.00
Fee paid to Carrier for mock cycle (if necessary)	$250.00
Travel for mock cycle (if necessary)	$3,000.00
Fee paid to Carrier in event of cancelled cycle	$500.00
Fee paid to Carrier in event of loss of reproductive organs or capabilities	$3,000.00
Additional post-birth lost wages in the event of a caesarean section	$1,200.00
Higher carrier compensation (for experienced carriers- avg.)	$5,000.00
Higher carrier compensation for carrier with insurance through Lloyd's from high demand states (e.g. CA, CT, MA, ME, RI, VT)	$5,000.00
Higher egg donor compensation (for experienced egg donors); additional for most expensive	$2,000.00
Additional legal fees, filing fees, DNA testing, twin supplement	$4,000.00
Additional Travel & Expenses for Carrier per transfer	$4,000.00
Additional Travel & Expenses for Egg Donor per transfer	$4,000.00
Local monitoring for Egg Donor	$3,000.00
Local monitoring for Carrier	$3,000.00
Additional copayments and deductibles (especially if using the Bridge plan)	$5,000.00

NOTES:

[1] It is difficult to advise you on how much the surrogacy process will cost. At one extreme, intended parents have successfully pursued traditional surrogacy free of charge. At the other extreme, an intended mother in another program spent $250,000 on 15 cycles with 8 different gestational carriers and three different agencies and never had a child. What we have in the cost sheet itself represents our best estimates of your costs. Intended parents are solely responsible for third-party expenses. Estimates in this cost sheet for third-party expenses are subject to change without notice.

[2] Exhibit numbers are listed for your convenience. They refer to corresponding items in the Agreement for Services.

[3] Occasionally, matches between intended parents and gestational carriers or egg donors are unsuccessful. This fee gives intended parents unlimited free rematches with gestational carriers and/or egg donors. Circle will charge no additional fees for future Carrier or Egg Donor Agreements. Additionally, Circle has agreements with the attorneys who most often represent carriers and egg donors and the person who provides psychological screenings so there will be no additional charges by these parties either.

[4] These are the estimates for the clinic Circle intended parents most often choose to work with. IVF charges vary depending on the clinic chosen and the financial plan selected by the intended parents.

[5] Insurance charges are some of the most variable expenses. Some gestational carriers have insurance with no surrogacy exclusions or a plan can be purchased for her in the state. Other surrogates are eligible for medical insurance made available through the Affordable Care Act (ACA). Enrollment in these plans must occur during a specific window. However, intended parents can purchase a Bridge the Gap insurance plan through Lloyd's that provides insurance coverage during the period between each enrollment period. These plans automatically convert into back-up insurance once ACA coverage begins. The $500 enrollment fee is for ART Risk Solutions and is subject to change without notice.

[6] About 10-15% of the time, an issue occurs with the surrogate's insurance covering expenses. The insurance management and defense fee includes our reviewing and/or procuring medical insurance policies for your surrogate as well as any required legal work in the event of a dispute with an insurance company or healthcare provider. This includes negotiating with providers, protecting surrogates and intended parents from credit agencies, and if necessary filing and fighting administrative appeals.

[7] Estimates listed in this section which relate to carrier's fees or reimbursements are subject to negotiation with your carrier and her attorney. Those listed are Circle's recommendations. Intended parents in our program should be prepared for charges 10 to 20% above the numbers quoted in the first two pages since travel, deductibles, second transfers (if not covered by a package), bed rest, lost wages, and twins represent common extra charges that can add to this number. To account for these potential additional expenses, we collect a $2,000 advance on miscellaneous expense and a $6,000 advance on contingencies which you could be responsible for under the Carrier Agreement. These funds are only used if needed, and are returned if not.

RMA of Connecticut

Financial Agreement

RMACT In -House Egg Donor, Gestational Carrier, Surrogacy Plan Plus

Donor Fees **$16,000.00**

Donor fees include: psychological testing and evaluation, all physician and nursing visits, checklist blood work and cultures, urine drug screening, FDA screening blood work, genetic testing, consultation with genetic counselor, medical insurance to cover the donor's cycle, and donor compensation ($8,000).

Gestational Carrier Fees **$3,000.00**

Gestational Carrier fees include: physician consultation, uterine evaluation, checklist blood work for both carrier and partner (if applicable), FDA screening blood work. *This fee can increase by $1,000.00 if psychological testing has not been completed by the surrogacy agency.*

Surrogacy Plan Plus **$44,000.00**

The Surrogacy Plan Plus includes: cycle medication for the oocyte donor and gestational carrier, anesthesia for the retrieval of oocytes, oocyte donor cycle monitoring completed at RMACT, oocyte retrieval, embryology laboratory charges, cryopreservation of embryos, cycle monitoring for the last ultrasound and blood tests prior to embryo transfer, embryo transfer into the gestational carrier, and the first year of embryo and specimen storage. If the donor cycle is cancelled prior to retrieval, the Surrogacy Plan Plus covers the cancellation cost, as well as the cost to rescreen the same or alternate donor. In the event the initial IVF cycle does not yield viable embryos, the Surrogacy Plan Plus includes the cost of one additional IVF cycle. If your gestational carrier cycle is cancelled before transfer, the Surrogacy Plan Plus covers the cancellation cost, as well as the cost to rescreen the same or alternate gestational carrier. In the event the initial frozen embryo transfer is unsuccessful, the Surrogacy Plan Plus covers the cost of unlimited frozen embryo transfers (*using embryos developed from the fresh donor IVF cycle*). The plan concludes once there is a live birth or after all frozen embryo has been transferred. In the event treatment does not result in a live birth, you will be refunded 100% cost of the Surrogacy Plan Plus ($44,000.00)

Total Cost: **$63,000.00**

Includes charges for; oocyte donors medical screening, gestational carrier medical screening, oocyte retrieval, frozen embryo transfer(s) to gestational carrier, cancellation charges before retrieval and transfer, donor and gestational carrier rescreening charge(s).

The following services are not covered

- Intended Parent(s) medical screening
- Gestational carrier compensation or legal fees
- Medical treatment associated with an unsuccessful cycle (treatment for miscarriage, ectopic or biochemical pregnancy)
- Pregnancy related treatment and pregnancy medications
- Medical services for the gestational carrier
- PGTA or PGD testing.
- Physician, Genetic, Nutrition consultations
- Cycle monitoring or outside monitoring for egg donor or the gestational carrier other than what is specified above
- Gestational carrier psychological evaluation and testing ($1,000)
- Mock cycle ($1,295) or ERA testing for the gestational carrier ($2,595)
- Oocyte cryopreservation ($1,720); TESA/MESA services *
- Storage of embryos or sperm beyond one year ($50.00 monthly each)
- In House Known Donor consultation ($125) or Skype ($200)

Patient Name (Please Print) _____ Partner Name (if applicable) (Please Print) _____ Date _____

RMA of Connecticut

Financial Agreement

RMACT In- House Egg Donor, Gestational Carrier, Surrogacy Plan Plus

By initialing below, I acknowledge and understand

_____ A $2,000.00 program deposit is required to access donor profiles and constitutes an agreement to work with RMACT. This deposit is not an additional charge and will be subtracted from the total cost of any procedures or services rendered by RMACT.

_____ Within 3 days of matching with an RMACT donor, your donor medical screening fee ($13,281.00), 75% of the Surrogacy Plan Plus ($33,000.00) is due.

_____ Payment for the Gestational Carrier medical screening is due prior to the screening visit. 25% of The Surrogacy Plan Plus ($11,000.00) is due once the Gestational Carrier has legal clearance.

_____ I understand the Surrogacy Plan Plus covers the cost of (1) cancelled donor cycle prior to retrieval. It covers the cost to rescreen the same or alternate donor. It covers the cost if the gestational carrier cycle is cancelled before transfer. It covers the cost to rescreen the same or (1) alternate gestational carrier. The Surrogacy Plan Plus covers cancellation cost rendered by RMACT.

_____ I understand the Surrogacy Plan Plus covers the cost of (1) additional IVF cycle if the initial cycle does not yield viable embryos.

_____ After the first year, storage of embryos and specimen will be billed to me at $50 a month, which is ($600.00 per year each) via Embryo Options. It is my responsibility to register and verify if I have specimen or embryos left after a cycle is complete. If I no longer want my embryos or specimen stored at RMACT I must have them transferred out or provide a signed and notarized disposal consent to cease billing. I can access this form via Embryo Options.

_____ Cancelled services that have been pre-paid in advance will be refunded less any balance owed. Refunds will be reimbursed by the method they were paid and can take up to 14 business days to process.

_____ Payment on all outstanding balances is required prior to the start of treatment. I understand that RMACT accepts cash, check, Discover, MasterCard, Amex, Visa and wire transfer.

_____ The plan concludes once there is a live birth or after all frozen embryos (*using embryos from the fresh donor IVF cycle*) has been transferred. In the event treatment does not result in a live birth, you will be refunded 100% cost of the Surrogacy Plan Plus ($44,000.00)

_____ I have received, read and understood The Surrogacy Plan Plus overview provided.

_____ I understand the RMACT In House Donor, Gestational Carrier, Surrogacy Plan Plus testing does not participate with any insurance plans. I understand this is an out of pocket cost, and my insurance will not be billed for any services covered under the RMACT In House Donor, Gestational Carrier, Surrogacy Plan Plus.

_____ All fees are subject to change.

At every step of the way your Insurance and Billing Advocates are here to help you, answer your questions, and provide you support. We wish you the best.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date
_____	_____	_____
Partner Name (if applicable) (Please Print)	Partner Signature	Date
_____	_____	
Financial Services Representative (Please Print)	Representative Signature	Date

Exhibit 2

Department of Financial Services

Industry Guidance

TO:	**All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, Health Maintenance Organizations, Student Health Plans Certified Pursuant to Insurance Law § 1124, Municipal Cooperative Health Benefit Plans, and Prepaid Health Services**
RE:	**Health Insurance Coverage of Infertility Treatments Regardless of Sexual Orientation or Gender Identity**

STATUTORY REFERENCES: N.Y. Insurance Law §§ 3216(l), 3221(h), 3221(k)(6), 4303(s), 4303(ll), and 4304(l)

I. Purpose

The purpose of this circular letter is to withdraw Insurance Circular Letter No. 7 (2017) and direct insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, and prepaid health services plans that issue coverage subject to Insurance Law §§ 3221(k)(6) and 4303(s) (collectively, "issuers") to provide immediate coverage of diagnostic and treatment services, including prescription drugs, for the diagnosis and treatment of infertility ("basic infertility treatments") for individuals who are unable to conceive due to their sexual orientation or gender identity and are covered under individual, small group, and large group health insurance policies and contracts.

II. Discussion

Insurance Law §§ 3221(k)(6) and 4303(s) require a policy or contract that provides coverage for hospital care or surgical and medical care to provide coverage for diagnostic and treatment procedures used in the diagnosis and treatment of infertility. These sections of the Insurance Law further require a policy or contract that provides coverage for prescription drugs to cover prescription drugs approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility. In addition, diagnostic and treatment procedures used in the diagnosis and treatment of infertility and prescription drugs are covered under comprehensive individual and small group health insurance policies and contracts as part of New York's essential health benefits package as described in Insurance Law §§ 3216(l), 3221(h), 4303(ll), and 4304(l).

In 2017, the Department of Financial Services ("Department") issued Circular Letter No. 7, which provided guidance to issuers based on the definition of "infertility" in effect at that time. In 2017, Insurance Law §§ 3221(k)(6)(C)(vi) and 4303(s)(3)(F) required issuers to make the determination of infertility in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and American Society for Reproductive Medicine ("ASRM"). The ASRM description of infertility provided that "[i]nfertility is a disease, defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women over age 35 years."

However, in 2019, Part L of Chapter 57 ("Part L") added Insurance Law §§ 3221(k)(6)(C)(v)(I) and 4303(s)(3)(E)(i) to amend the definition of "infertility" that was set forth in former Insurance Law §§ 3221(k)(6)(C)(vi)(I) and 4303(s)(3)(F)(i) to mean "a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings."

Part L also added new Insurance Law §§ 3221(k)(6)(C)(viii) and 4303(s)(3)(H) to prohibit an issuer providing coverage for infertility treatments from discriminating based on an individual's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, or based on personal characteristics, including age, sex, sexual orientation, marital status, or gender identity. Part L further added a new Insurance Law §§ 3221(k)(6)(C)(vii) and 4303(s)(3)(G) to require large group policies that provide medical, major medical or similar comprehensive-type coverage to cover three cycles of in-

vitro fertilization ("IVF") when used in the treatment of infertility. The amendments made by Part L took effect on January 1, 2020 and applied to insurance policies and contracts issued, renewed, modified, altered, or amended on or after January 1, 2020.

Under the Insurance Law, an issuer must provide coverage regardless of sexual orientation, marital status, or gender identity. In addition, since the definition of infertility expressly contemplates coverage for infertility treatment earlier than 12 months, issuers should be mindful that, with respect to some individuals, earlier evaluation and treatment may be justified. It has come to the Department's attention that some issuers may be requiring some individuals to incur costs, due to their sexual orientation or gender identity, that heterosexual individuals do not incur in order to meet the definition of infertility. In particular, some issuers have denied coverage of basic infertility treatments, such as intrauterine insemination procedures, for some individuals who are unable to conceive without such treatment due to their sexual orientation or gender identity. These individuals may incur the high costs of basic infertility treatments for up to 12 months to demonstrate infertility in order to qualify for insurance coverage due to their sexual orientation or gender identity. This results in unfair discrimination for individuals due to their sexual orientation or gender identity, which is prohibited by Insurance Law §§ 3221(k)(6)(C)(viii) and 4303(s)(3)(H). Therefore, issuers must provide immediate coverage for basic infertility treatments (e.g., intrauterine insemination procedures) that are provided to individuals covered under an insurance policy or contract who are unable to conceive due to their sexual orientation or gender identity in order to prevent discrimination. Issuers that cover IVF procedures may consider whether basic infertility treatments, such as intrauterine insemination procedures, would be medically appropriate for the individual to attempt prior to covering IVF. This circular letter does not address surrogacy arrangements or require coverage for services that are not otherwise mandated to be covered under the Insurance Law.

III. Conclusion

Issuers are directed to provide immediate health insurance coverage for basic infertility treatments that are provided to individuals covered under an insurance policy or contract who are unable to conceive due to their sexual orientation or gender identity in accordance with the Insurance Law. In addition, Circular Letter No. 7 (2017) is withdrawn.

Please direct any questions regarding this circular letter by email to health@dfs.ny.gov.

Very truly yours,

Lisette Johnson

Chief, Health Bureau

Who We Supervise

Institutions That We Supervise

The Department of Financial Services supervises many different types of institutions. Supervision by DFS may entail chartering, licensing, registration requirements, examination, and more.

Learn More

Department of Financial Services

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Mission and Leadership

Advisory Boards

Institutions That We Supervise

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Exhibit 3

City of New York Employees and Retirees

HEALTH INSURANCE FOR YOU AND YOUR DEPENDENTS

GHI Comprehensive Benefits Plan (CBP)

EmblemHealth®
WHAT CARE FEELS LIKE.

Important Notice

We believe this Policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service by calling **(212) 501-4444** or visiting our Web site at **www.emblemhealth.com**. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**. Your group must notify us if the group or the plan sponsor changes the premium contribution rate that applies to your coverage under this Policy at any point during the plan year.

Out-of-Network Cost Notice

The GHI Comprehensive Benefits Plan (CBP) gives you the freedom to choose in-network or out-of-network doctors. You can see any network doctor without a referral. Covered services from out-of-network doctors have deductibles and coinsurance. Payment for services provided by out-of-network providers is usually made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges. The reimbursement rates in the Schedule are not related to usual and customary rates or to what the provider may charge but are set at a fixed amount based on GHI's 1983 reimbursement rates. Most of the reimbursement rates have not increased since that time, and will likely be less (and in many instances substantially less) than the fee charged by the out-of-network provider. You will be responsible for any difference between the provider's fee and the amount of the reimbursement; therefore, you may have a substantial out-of-pocket expense.

Estimate your out-of-pocket costs for care from out-of-network providers.

If you intend to use an out-of-network provider, you can obtain an estimate of the out-of-network reimbursement rate for the anticipated medical procedure by utilizing GHI's CBP Allowance Calculator, which is available online in the GHI-CBP members' section at www.emblemhealth.com, or by calling GHI Member Services at **(800) 624-2414**. Prior to utilizing the CBP Allowance Calculator or calling Member Services, you must obtain from the out-of-network provider the medical procedure code(s) (CPT Codes) for the service(s) you anticipate receiving.

Below are some examples of what you would typically pay out of pocket if you were to receive care or services from an out-of-network provider.

TYPICAL OUT-OF-POCKET COSTS FROM RECEIVING CARE FROM OUT-OF-NETWORK PROVIDERS	
Established Patient Office Visit (typically 15 minutes) — CPT Code 99213	
Estimated Charge for a Doctor in Manhattan	$215
Reimbursement Under the Schedule	- $36
Member Out-of-Pocket Responsibility	$179
Routine Maternity Care and Delivery — CPT Code 59400	
Estimated Charge for a Doctor in Manhattan	$9,500
Reimbursement Under the Schedule	- $1,379
Member Out-of-Pocket Responsibility	$8,121
Total Hip Replacement Surgery — CPT Code 27130	
Estimated Charge for a Doctor in Manhattan	$20,000
Reimbursement Under the Schedule	- $3,011
Member Out-of-Pocket Responsibility	$16,989

Estimated Charge is set at FAIR Health's 80th percentile and is based on Manhattan zip codes with a 100 prefix.

Please note that deductibles may apply and that you could be eligible for additional reimbursement if your catastrophic coverage kicks in or you have purchased the Enhanced Non-Participating Provider Schedule, an Optional Rider benefit that provides lower out-of-pocket costs for some surgical and in-hospital services from out-of-network doctors. The Optional Rider Enhanced Non-Participating Provider Schedule increases the reimbursement of the basic program's non-participating provider fee schedule for some in-hospital services on average, by 75%.

There are circumstances when you may unknowingly be treated by out-of-network doctors. Typically this occurs during a hospital admission (inpatient or outpatient, emergency or non-emergency) when services are provided by out-of-network doctors – even if the hospital is an in-network hospital and/or some of the doctors are in GHI's provider network. For example, during an emergency room hospital admission, you may be treated by a plastic surgeon who works at an in-network hospital, but is not in GHI's provider network, or, during a scheduled out-patient procedure, even when the hospital is an in-network hospital and the doctor performing the procedure is an in-network doctor, you may also receive services from an out-of-network doctor who works at the hospital, such as an anesthesiologist, radiologist, or pathologist, but is not part of GHI's provider network. Even though that doctor works at an in-network hospital, if the doctor is an out-of-network doctor, you will be responsible for your out-of-network cost sharing and the balance of that doctor's bill after GHI reimburses at the rate from its Schedule. However, for services rendered on or after April 1, 2015, you will be protected from out-of-pocket costs, other than applicable

in-network cost-sharing, for services that qualify as "surprise bills" or emergency services as described below. In the event that the protections set forth below do not apply, your out-of-pocket expenses may be substantial, since the out-of-network doctors will be covered under your benefits the same as any other out-of-network doctor, in many instances.

Protection from Surprise Bills For Services Rendered On Or After April 1, 2015.

A surprise bill is a bill you receive for covered services provided in New York State on and after April 1, 2015 in the following circumstances:

- For services performed by a non-participating physician at a participating hospital or ambulatory surgical center, when:
  - A participating physician is unavailable at the time the health care services are performed;
  - A non-participating physician performs services without your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating physician is available and you elected to receive services from a non-participating physician.

- You were referred by a participating physician to a non-participating provider without your explicit written consent acknowledging that the referral is to a non-participating provider and it may result in costs not covered by us. For a surprise bill, a referral to a non-participating provider means:
  - Covered services are performed by a non-participating provider in the participating physician's office or practice during the same visit;
  - The participating physician sends a specimen taken from you in the participating physician's office to a non-participating laboratory or pathologist; or
  - For any other covered services performed by a non-participating provider at the participating physician's request, when referrals are required under your plan.

The level of reimbursement provided under the Basic NYC Non-Participating Provider Schedule for covered Out-of-network services equates, in the aggregate, to approximately 14.5% of the usual, reasonable and customary (UCR) charge (i.e. Fair Health 80th percentile fee schedule). For procedures covered under the High Option rider in combination with the basic NYC Non-Participating Provider Schedule for covered Out-of-network services the basic reimbursement noted above will be increased on a weighted average basis of 65% based on paid claims. For procedures covered under the Catastrophic option rider in combination with the basic NYC Non-Participating Provider Schedule for covered Out-of-network services the basic reimbursement noted above will be increased on a weighted average basis of 112%.

See the "Out-Of-Network Reimbursement Examples for GHI CBP" chart in Section III - Additional Program Information, for more out-of-network reimbursement examples.

You will be held harmless for any non-participating provider charges for the surprise bill that exceeds your in-network copayment, deductible or coinsurance if you assign benefits to the non-participating provider in writing. In such cases, the non-participating provider may only bill you for your in-network copayment, deductible or coinsurance.

The assignment of benefits form for surprise bills is available at **www.dfs.ny.gov** or you can visit GHI's website at **www.emblemhealth.com** for a copy of the form. You need to complete and mail a copy of the assignment of benefits form to GHI at the address on GHI's website and to your provider.

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

Payments Relating to Emergency Services Rendered. The amount we pay a non-participating provider for covered services you receive in a hospital to treat an emergency condition on or after April 1, 2015 that are not payable under your hospital plan will be an amount we have negotiated with the Non-Participating Provider for the service or an amount we have determined is reasonable for the service. An emergency condition means: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

If a dispute involving a payment for physician services relating to emergency services payable by us is submitted to an independent dispute resolution entity ("IDRE"), we will pay the amount, if any, determined by the IDRE for physician services.

You are responsible for any in-network copayment, deductible or coinsurance. You will be held harmless for any non-participating provider charges that exceed your copayment, deductible or coinsurance in these circumstances.

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SECTION I

Certificate of Insurance

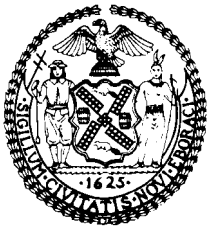
GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

HEALTH INSURANCE FOR YOU AND YOUR DEPENDENTS

FOR THE CITY OF NEW YORK EMPLOYEES AND RETIREES COMPREHENSIVE BENEFITS PLAN (CBP)



GROUP HEALTH INCORPORATED

The insurance evidenced by this Certificate meets the minimum standards for basic medical insurance as defined by the New York State Insurance Department.

It does not provide basic hospital insurance or major medical insurance.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT PLAN.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from GHI.

This Certificate replaces any Certificates and riders previously issued to you.

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SECTION ONE: Introduction

1. Your Coverage Under GHI/CBP. The City of New York has entered into a Group Contract with Group Health Incorporated (GHI) to provide health insurance benefits. Under this Group Contract, GHI will provide the benefits described in this booklet to persons enrolled in the New York City Employee Benefits Program. These benefits are known as the GHI Comprehensive Benefits Plan (GHI/CBP) and will be referred to in this booklet as GHI/CBP or "this Plan." This booklet is your Certificate of Insurance. It is evidence of your coverage under the Group Contract between GHI and the City of New York. It is not a contract between you and GHI. You should keep this booklet with your other important papers so that it is available for your future reference.

2. Who is Covered. Eligibility for coverage is determined by the City of New York Employee Benefits Program. Please refer to the Health Benefits Summary Program Description booklet for information on your eligibility for coverage. Also, please refer to that booklet for an explanation of how you enroll in GHI/CBP, and when your coverage becomes effective.

3. Coverage of Spouse and Dependent Children. Benefits are available for your spouse and unmarried dependent children under the age of 19 covered by your plan. Unmarried dependent children are covered until the end of the month in which they attain age 19. Your newborn child is covered at birth. You must add the child to your Contract according to procedures described in your Health Benefits Summary Program Description booklet.

If you have individual coverage, you may elect to cover your newborn child from the moment of birth for injury or sickness. You must add the newborn child to your coverage within 30 days of the child's birth. This will change your present coverage to family coverage.

If a child of yours gives birth, the newborn grandchild is not eligible for coverage unless the child meets the rules for dependents who are not natural children. These rules are listed below.

Please note, an ex-spouse is never covered under this plan regardless of the provisions of any divorce judgment or settlement agreement. The submitting of a claim by or for an ex-spouse of a covered employee is insurance fraud.

A dependent who is not your spouse or natural child is covered at the earliest of the following dates:

(a) The child becomes an adoptive child or step-child or lives with you in a regular parent/child relationship. The child must be dependent upon you for support and maintenance. You must claim the child as a dependent on your Federal Income Tax return. A dependent adoptive child will be covered on the same basis as a natural child during any waiting period prior to finalization of the adoption.

(b) A court of law accepts a consent to adopt and you enter into an agreement to support the dependent child.

(c) A court of law makes you legally responsible for the support and maintenance of the dependent child.

(d) If you have family coverage, an adopted newborn is covered from the moment of birth for injury and sickness. You must take physical custody of the newborn upon the newborn's release from the hospital. You must also file a petition for adoption or an application for temporary guardianship pursuant to Section 115(c) of the New York State Domestic Relations Law within 30 days after the child's birth. Benefits for the adopted newborn's initial hospital stay are not available under this Plan if a natural parent has insurance coverage available to cover the newborn.

4. Coverage of Dependent Students. Coverage for unmarried dependent full-time students ages 19 to 23 is provided only under the Optional Rider. If you are covered under the Basic CBP Program only, your dependent children who are 19 years of age or older will not be covered. To qualify for dependent student coverage, the student must be enrolled in an accredited educational institution. The institution must grant a degree or diploma. You must supply at least 50% of the student's support. The student must be listed as a dependent when you enroll for coverage. Benefits are available for all covered services. An unmarried dependent student loses eligibility if he or she marries, loses dependent status or loses full time student status. An unmarried dependent student is covered until the end of the calendar year of the student's 23rd birthday or graduation, whichever occurs first.

5. Coverage of Dependent Children Incapable of Self-Sustaining Employment. An unmarried child over age 19 (or over age 23 in the case of a dependent student) may also be eligible for benefits. In order to be eligible, he or she must meet all of the conditions set forth below.

(a) He or she must be incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation as defined in the New York State Mental Hygiene Law, or physical handicap.

(b) He or she must have been so incapable before the age at which dependent coverage would otherwise terminate.

(c) He or she must have been eligible for benefits before the age at which dependent coverage would otherwise terminate.

(d) The child's condition must be certified by a physician.

(e) Proof of the condition must be submitted to GHI within 31 days of the date the dependent reaches the age limitation.

GHI has the right to check whether a child is eligible and continues to qualify under this provision.

6. Domestic Partners. Benefits are available for your covered domestic partner and his or her eligible dependents. The domestic partnership must consist of two people who are 18 years of age or older and who live together and have been living together on a continuous basis for at least six (6) months. The domestic partnership must involve a close and committed personal relationship. Neither you nor your domestic partner may be married or related by blood in a manner that would bar marriage in New York State. Your domestic partner must be chiefly dependent upon you for support and maintenance.

In order to be eligible for coverage, you must show that you and your domestic partner are economically interdependent by meeting the criteria set forth below.

(a) The domestic partnership must be registered under the Domestic Partnership Registration Program of the City of New York Office of the Mayor as well as with the City Clerk. (In the case of retirees living outside of the City of New York, an alternate affidavit of domestic partnership recognized by the City of New York may be presented in lieu of registration.)

(b) You must supply proof of cohabitation. This may be shown by means of drivers' licenses, tax returns or other proof recognized by the City of New York.

(c) You must present evidence of at least two of the indications of economic interdependency set forth below.

- A joint bank account.
- A joint credit or charge card.
- A joint obligation on a loan.
- Status as an authorized signatory on your domestic partner's bank account, credit card or charge card.
- Joint ownership or holding of investments.
- Joint ownership of a residence.
- Joint ownership of real estate other than a residence.
- Listing of both you and your domestic partner as tenants on the lease of a shared residence.
- Shared rental payments for a residence.
- Listing of you and your domestic partner as tenants on a lease or shared rental payments for property other than a residence.
- A common household and shared household expenses, such as grocery bills, utility bills and telephone bills.
- Shared household budget for purposes of receiving government benefits.
- Status of one as representative payee for the other's government benefits.
- Joint ownership of major items of personal property, such as appliances and furniture.
- Joint ownership of a motor vehicle.
- Joint responsibility for child care. This may be shown be means of school documents, guardianship papers or similar documents.
- Shared child care expenses, such as baby sitting, day care and school bills.
- Execution of wills naming each other as executor and/or beneficiary.
- Designation of one as beneficiary under the other's life insurance policy.

- Designation of one as beneficiary under the other's retirement benefits account.
- Mutual grant of power of attorney.
- Mutual grant of authority to make health care decisions, such as a health care power of attorney.
- Affidavit by a creditor or other individual able to testify to your partner's financial interdependence.
- Other items of proof acceptable to the City of New York showing economic interdependency.

7. If You Are Disabled on the Date Your Coverage Becomes Effective. On the day your coverage becomes effective you may be confined due to a disability, in a hospital, another institution, or in your home under the care of a doctor. If this is the case, you are not eligible for benefits until you are no longer confined.

The dependent children of your covered domestic partner are also covered. The eligibility terms set forth in paragraphs 3, 4 and 5 above apply.

8. Scope of Coverage. This Plan consists of two types of benefits. The type of benefit you receive is dependent on whether or not you use a Participating Provider. A Participating Provider is any doctor or other Provider who has agreed with GHI to accept GHI's payment as payment in full for covered services, except in cases where a Co-pay Charge is applicable. If you use a Participating Provider, payments are generally made directly to that Provider. These payments are made in accordance with the CBP Schedule of Allowances. Except for home and office visits, specialist consultations, diagnostic, X-ray and laboratory tests which are subject to a Co-pay Charge, these benefits are paid at 100% of the CBP Schedule and are not subject to co-insurance, deductibles, or lifetime maximums. Most, but not all, of your benefits are available through Participating Providers.

If you use a non-participating Provider, payment is made directly to you. Payment is determined under the City of New York Non-Participating Provider Schedule. These benefits are subject to deductibles, co-insurance and calendar year and lifetime maximums.

Special terms apply to coverage of private duty professional nursing services, durable medical equipment, home care services and home infusion therapy. (See Section Five, Paragraphs 15, 16, 24 and 25 respectively).

9. Medicare. If you are eligible for Medicare, your benefits may be different than the benefits described in the main body of this booklet. Refer to Section Fourteen for an explanation of your benefits.

10. Criteria for Coverage. You are covered only for the services listed in this Contract. The services must be rendered by a licensed Provider. The Provider must act within the scope of his or her license. GHI does not cover services unless they are medically necessary. Medically necessary services are health care services that are rendered by a Hospital or a licensed Provider and are determined by GHI to meet all of the criteria listed below:

- They are provided for the diagnosis, or direct care or treatment of the condition, illness, disease, injury or ailment;
- They are consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or aliment;
- They are in accordance with accepted standards of good medical practice in the community;
- They are furnished in a setting commensurate with the patient's medical needs and condition;
- They cannot be omitted under the standards referenced above;
- They are not in excess of the care indicated by generally accepted standards of good medical practice in the community;
- They are not furnished primarily for the convenience of the patient, the patient's family or the Provider; and
- In the case of a hospitalization, the services cannot be rendered safely or adequately on an outpatient basis and, therefore, require that the patient receive acute care as a bed patient.

In making a determination regarding medical necessity, GHI will examine your treatment and your condition. GHI will examine your doctor's reasons for providing or prescribing the care, and any unusual circumstances. However, the fact that your doctor prescribed or provided the care does not automatically mean that the care qualifies for payment under this Plan.

GHI may require that a Provider's statement be furnished detailing the nature and necessity of a rendered service. This statement must be provided, if requested, in order for your claim to be processed. It must be in a form acceptable to GHI.

SECTION TWO: Definitions

The following definitions apply to your benefits:

l. Schedule of Allowances. The CBP Schedule of Allowances ("Schedule") is GHI's listing of the payments for covered medical services rendered by Participating Providers. Payment is made under the Schedule directly to a Participating Provider.

The City of New York Non-Participating Provider Allowed Charge refers to the amount allowed for reimbursement to Non-Participating Providers. This amount less any applicable deductible or co-insurance is reimbursed directly to you. See Section Four. (See definition number 9 below.)

A listing of the Schedule of Allowances and Allowed Charges is on file at GHI's home and regional offices and with the Superintendent of Insurance, State of New York Insurance Department. It is available for your inspection, at these locations, upon your request, at any reasonable time during regular business hours.

2. Provider. A "Provider" is a medical practitioner or covered facility recognized by GHI for reimbursement purposes. A Provider may be any of the providers listed below, subject to the conditions set forth in this paragraph.

1. A doctor of medicine.
2. A doctor of osteopathy.
3. A dentist.
4. A chiropractor.
5. A doctor of podiatric medicine.
6. A physical therapist.
7. A nurse midwife.
8. A certified and registered psychologist.
9. A certified and qualified social worker.
10. An optometrist.
11. A nurse anesthetist.
12. A speech therapist.
13. An audiologist.
14. A clinical laboratory.
15. A screening center.
16. A general hospital.
17. Any other type of practitioner or facility specifically listed in this Certificate as a practitioner or facility recognized by GHI for reimbursement purposes.

A Provider must be licensed or certified to render the covered service. The covered service must be within the scope of the Provider's license or certification. Please note that not all services rendered by a specific class of Providers listed above are covered services. In order for you to be covered, the service rendered to you must be covered. In addition, the practitioner or facility rendering the service must be listed in this Certificate as a Provider who is recognized by GHI to render the covered service. Please refer to the benefit description to find out if a service is covered.

3. Participating Provider. A Participating Provider is any doctor or other Provider who has agreed with GHI to accept GHI's payment as payment in full for covered services, except in cases where a Co-pay Charge is applicable. Consult your Directory of Participating Physicians and other Providers for the names of Participating Providers. You may also call or write GHI for this information. Most, but not all, covered services are available through Participating Providers.

4. You. The word "you" refers to you, the employee or retiree and to any members of your family who are covered under this Plan.

5. Group Contract. The Group Contract is the agreement GHI has with the City of New York.

6. Certificate of Insurance. This document is your Certificate of Insurance. It is evidence of your coverage under the Group Contract.

7. Contract. The word "Contract" in the text refers to this Certificate.

8. Hospital. Hospital means a psychiatric hospital or general hospital that has medical and surgical facilities for the care and treatment of the sick. A hospital is not one of the following:

(a) An old age, rest or nursing home.
(b) A convalescent home or similar institution.
(c) A sanitarium.
(d) A camp, school, college or university infirmary.
(e) A facility for the treatment of mental problems, tuberculosis, drug abuse or alcoholism.
(f) A weight loss or fitness center.
(g) A skilled nursing center or facility.
(h) An institution utilized primarily for custodial care or as a domicile.
(i) Health resorts or spas.
(j) Places for hospice care treatment.
(k) Rehabilitation facilities.

9. Allowed Charge. Allowed Charges are the various scheduled amounts which GHI will reimburse for covered services rendered by non-participating providers. The Allowed Charge schedules may vary depending upon the type of covered service you receive, and the applicable level of benefits. Allowed Charges are based upon data collected by GHI and agreed to by the City of New York.

Allowed Charges for basic benefits for covered services which are rendered by non-participating providers are based upon 1983 procedure allowances. Some allowances have been increased from time to time. The Allowed Charge may be less than the fee charged by a non-participating provider. You must pay any difference between the Allowed Charge and the non-participating provider's fee as well as any applicable cost sharing provision.

The Optional Rider provides an enhanced Allowed Charge schedule which results in greater reimbursement for most covered services. See the Optional Rider for Active Employees and Non-Medicare Eligible Retirees in this booklet for a description of the Optional Rider coverage.

There are different Allowed Charge schedules that apply to excess hospitalization coverage, catastrophic coverage and ambulance coverage.

There may be occasions where GHI does not have an Allowed Charge for a particular service. When this is the case, GHI will make payment based upon either Medicare guidelines and/or the Relative Value Scale to determine comparability between procedures. The Relative Value Scale is a standard of rating generally acceptable in the health insurance field.

In the event that the Provider's actual and customary billed charge is less than GHI's Allowed Charge, GHI will consider the Provider's charge to be GHI's Allowed Charge for the covered service rendered to you.

10. Co-Pay Charge. Co-Pay Charge refers to a fixed dollar amount you must pay to a Participating Provider for certain services.

SECTION THREE: Use of Participating Providers for Paid-In-Full Benefits

1. Participating Providers. GHI Participating Providers accept GHI's Schedule of Allowances as payment in full for covered services. There is no deductible or co-insurance when you use a Participating Provider. However, there is a $10 Co-pay Charge for each home or office visit and out-of-hospital consultation.

You are also subject to a $10 Co-pay Charge for diagnostic X-rays and laboratory tests. This Co-pay Charge will apply to each diagnostic X-ray and laboratory test performed by a Participating Provider. A maximum of one Co-pay Charge will apply per date of service, per provider. This means that if one Participating Provider performs two tests on the same day, you will be subject to one $10 Co-pay Charge only. However, if two different Participating Providers perform one or more lab tests each on the same day, you will be subject to a maximum of two Co-pay Charges of $10 each. A maximum of two diagnostics Co-pay Charges will apply per date of service. This maximum applies regardless of the number of Participating Providers you see on that date.

Special terms apply to coverage of private duty professional nursing services, durable medical equipment, home care services and home

infusion therapy. (See Section Five, Paragraphs 23, 24, 21 and 22 respectively).

The use of Participating Providers controls your out-of-pocket expenses. Consult your Directory of Participating Physicians and other Providers or phone GHI to obtain the names of Participating Providers in your area.

You must advise the Participating Provider of your GHI/CBP coverage before the service is rendered. You must verify that the Provider is a Participating Provider. You should not pay the provider directly for any covered services except for the $10 Co-pay Charge when applicable.

2. Services Provided by Participating Providers. Participating Providers have agreed to accept GHI's payment as payment in full for the following:

(a) General Medical Care, subject to the $10 Co-pay Charge.
(b) In-Hospital Medical and Psychiatric Care.
(c) Surgical Services.
(d) Assistants at Surgery.
(e) Administration of Anesthesia.
(f) Radiation Therapy.
(g) Shock Therapy.
(h) Specialist Consultations, subject to the $10 Co-pay Charge.
(i) Diagnostic X-ray Examinations, subject to the $10 Co-pay Charge.
(j) Diagnostic Laboratory Tests, subject to the $10 Co-pay Charge.
(k) Maternity Care.
(l) Care of Premature and Ill Infants.
(m) Chiropractic Care, subject to the $10 Co-pay Charge.
(n) Physiotherapy, subject to the $10 Co-pay Charge.
(o) Speech Therapy, subject to the $10 Co-pay Charge.
(p) Intermittent Nurse Service in Your Home (Visiting Nurse Service).
(q) Allergy Desensitization, subject to the $10 Co-pay Charge.
(r) Osteopathic manipulations, subject to the $10 Co-pay Charge.
(s) Mammography Screening Examinations.
(t) Orthoptic services (eye muscle exercise), subject to the $10 Co-pay Charge.

3. Benefits Available. Most, but not all services covered under this Certificate are available through Participating Providers.

SECTION FOUR: Use of Non-Participating Providers

1. Non-Participating Providers. You may choose any Provider you want for covered services. You may select a non-participating Provider. Non-participating Providers do not have an agreement with GHI to limit fees. You must pay them directly. Reimbursement for covered services will be made directly to you according to the City of New York Non-Participating Provider Schedule. These benefits are subject to deductibles, co-insurance, and maximums.

2. Benefits. When you use a non-participating Provider, benefits are paid under the City of New York Non-Participating Provider Schedule in accordance with the Allowed Charge for all services. (See Section Two, paragraph 9).

These benefits are subject to the following provisions:

(a) **Annual Deductible.** You are subject to an annual deductible of $175 per person up to a maximum deductible for a family of three or more of $500 in each calendar year. GHI will make payment to you after you have paid this amount. The amount credited to your deductible shall be based on the Allowed Charge.

(b) **Common Accident Provision.** More than one family member may be involved in an accident. If that occurs, only $175 in allowed expenses are required to satisfy the deductible for that accident, for all covered persons involved. The $175 is first applied towards the Subscriber's deductible. If the Subscriber was not involved, it is applied toward the oldest member of the family who was involved.

(c) **GHI Payments.** After you have met your deductible, GHI will pay 100% of the Allowed Charge for covered services.

(d) **Annual Maximum.** Each person is subject to a calendar year maximum of $200,000 in covered expenses. Only $100,000 of this maximum may be used toward Private Duty Professional Nursing Services.

(e) **Lifetime Maximum.** Each person is subject to a lifetime maximum of $1,000,000 in covered expenses.

Special terms apply to coverage of private duty professional nursing services, durable medical equipment, home care services and home infusion therapy. (See Section Five, Paragraphs 23, 24, 21 and 22 respectively).

SECTION FIVE: Covered Medical Services

GHI provides benefits for the covered medical services listed below. Unless otherwise specified, benefits are available through both Participating and non-participating Providers.

All claims for services must contain specifics as to the services rendered. GHI reserves the right to delay the processing of claims when the Provider only lists a general fee until GHI receives the specifics as to the services rendered.

l. General Medical Care. You are covered for home and office visits. Payments are made for the following types of services:

(a) Treatment or diagnosis of illness or injury.

(b) Allergy desensitization.

(c) Physiotherapy.

(d) Speech therapy.

(e) Chiropractic care (limited to a maximum of 8 visits per calendar year).

(f) Emergency first aid service.

(g) Osteopathic manipulation.

(h) Orthoptic services.

Under the Participating Provider Program, a $10 Co-pay Charge applies to home and office visits.

All visits are subject to utilization review. As with all covered services, the service that is rendered to you must be medically necessary. GHI may require that a current Provider's statement, acceptable to GHI, be furnished detailing the medical necessity of any service. In some cases, GHI may request that a treatment plan and statement be filed at the commencement of your treatment. In all cases, GHI will require that a current Provider's statement be furnished after the following number of visits for the following services:

(a) Speech therapy, l6 visits.

(b) Allergy desensitization, l6 visits.

(c) Physiotherapy, 8 visits.

(d) Osteopathic manipulations, 8 visits.

(e) Orthoptic services, 8 visits

2. Preventive Care. You are covered for Preventive Care services set forth below. Please see Paragraph 23 of this Section for covered

preventive and primary care services for dependent children.

(a) Mammography Screening. You are covered for mammography screening as set forth below. A "mammography screening" is a breast X-ray which is done using dedicated mammography equipment.

1. A mammography at any time if recommended by a physician.
2. A single baseline mammography if you are 35 through 39 years of age.
3. A mammography every two year if you are 40 through 49 years of age. This benefit may be covered more frequently if recommended by your physician.
4. An annual mammography if you are 50 years of age or older.

(b) Pap Smear Screening. You are covered for one annual Pap smear screening. You must be 18 years of age or older. Your Pap smear screening includes the following:

(i) An annual pelvic examination.

(ii) Then collection and preparation of a Pap smear.

(iii) The laboratory and diagnostic services needed to examine and evaluate the Pap smear.

You are not covered for the following Preventive Care services, except as set forth above.

(a) Annual physicals.

(b) Immunizations.

(c) Screening examinations.

3. Surgery. You are covered for surgical procedures in or out of the hospital. The customary pre- and post-operative visits are included in your payment. In order for you to receive benefits, the surgeon may not be an employee of the hospital.

Certain surgical procedures are subject to the requirements of the NYC HEALTHLINE Program and may require a mandatory second surgical opinion. If the requirements of the NYC HEALTHLINE Program are not met, you may be subject to penalties. (See Section Six).

If multiple surgical procedures are performed through the same incision, GHI will pay the rate for the procedure with the highest allowance. If multiple surgical procedures are performed through different incisions, GHI will pay 100% of the surgical allowance for the most expensive procedure being performed plus one-half the allowance for any other procedure being performed.

You are covered for the services of assistant surgeons. Payment for the first assistant surgeon are based upon 20% of the Surgical Allowance. Payment for a second assistant are based upon 10% of the Surgical Allowance. A physician's assistant is covered in lieu of an assistant surgeon. The first physician's assistant is covered at 15% of the surgical allowance. The second physician's assistant is covered at 7.5% of the surgical allowance.

4. Dental/Dental Related Benefits. The following benefits are the only dental/dental related benefits covered under this Certificate. They may be performed by either a physician or dentist.

(a) Excision of impacted teeth.

(b) Reduction of fractures of the jaw or facial bones.

(c) Treatment of salivary gland disorders.

(d) Cutting surgery on tissue of the mouth other than the gums and alveolar bone. The surgery cannot be rendered in connection with the extraction, repair or replacement of the teeth. Implants and implant sugery, including preparation of the alveolar process for the insertion of dental implants, are not covered. Removal of cysts of dental origin is not covered.

(e) Treatment rendered within one year of the date of an accident for the repair of injury to natural teeth sustained accidentally.

(f) Visits for the purpose of diagnosis or treatment of temporo-mandibular joint dysfunction (TMJ) syndrome. However, dental examinations and/or dental x-rays, even if taken in conjunction with a TMJ syndrome diagnosis, are not covered. Treatment of TMJ syndrome by occlusional adjustment is not covered. You are not covered for intra-oral appliances or orthopedic devices and their maintenance.

5. Administration of Anesthesia. You are covered for the administration of Anesthesia. In order for you to receive benefits, your Provider may not be your surgeon, an assistant surgeon, or a hospital employee. The anesthesia must be rendered in connection with a covered surgical or obstetrical service. Payments for anesthesia include the administration of blood and other fluids during surgery.

Payments for the administration of Anesthesia will be based on the surgical procedure performed and the amount of time spent by the anesthesiologist.

6. Maternity Care. You are covered for childbirth and for certain conditions related to pregnancy. This includes operations for extra-uterine pregnancies and the treatment of miscarriages. You are also covered for terminations of pregnancies. GHI's payment includes the usual care given before and after the delivery or termination of pregnancy.

GHI shall pay maternity benefits in three installments. Two payments shall be made for pre-natal care and one payment for delivery and post-partum care. Payments shall be made only for services rendered. A claim for the services must be filed with GHI for each installment. GHI shall pay 15% of the Scheduled or Allowed amount at the first installment. GHI shall pay 25% of the Scheduled or Allowed amount at the second installment. And GHI shall pay 60% of the Scheduled or Allowed amount at the third installment. In no event shall GHI pay more than the 100% of the Scheduled or Allowed amount in its total payments.

Claims for services rendered may only be submitted after the installment date. Please note, you may still submit your entire claim after delivery.

The following is GHI's schedule of installment dates:

(a) First installment: Three months after conception.

(b) Second installment: Six months after conception.

(c) Third installment: After delivery.

Maternity care must be rendered by a doctor or certified nurse midwife. The nurse midwife must be permitted to perform the service under the laws of the State where the services are rendered.

Complications of pregnancy are covered as part of your maternity benefit. Separate reimbursement is not available for such complications.

Benefits are available for maternity upon enrollment. Deliveries occurring after your coverage terminates are not covered under this Plan, except as provided in Section Ten, Paragraph 2.

7. In-Hospital Medical Care. You are covered for medical care rendered in the hospital. In order to be covered, the care may not be provided by a hospital employee. The Provider's service must be unrelated to surgery.

In-hospital medical care consists of the following:

(a) Routine Medical Care.

(b) Psychiatric Care rendered by a physician, certified and registered psychologist or a certified social worker. The social worker must be qualified as a Provider for third-party reimbursement under the laws of New York State. He or she must have six years of post-Masters Degree supervised Psychotherapy experience. Psychiatric care may be rendered in either a general or psychiatric hospital. Custodial care is not covered.

(c) Care of premature infants and illness of newborns.

(d) Intensive Care.

8. Radiation Therapy. You are covered for the administration of radiation therapy. This Certificate does not cover the cost of radium or other radioactive materials.

9. Chemotherapy. You are covered for chemotherapy. Coverage for chemotherapy includes coverage for drugs dispensed by a physician or pharmacy.

10. Specialist Consultations. Your doctor may want you to see a Specialist. The Specialist may or may not be a Participating Provider. If you wish to use a Specialist who is a Participating Provider, you may call GHI for a list of Participating Specialists in your area. Under the

Participating Program, a $10 Co-pay Charge applies to Specialist consultations.

You are covered for one out-of-hospital consultation in each specialty per calendar year, for each condition being treated.

You are covered for one in-hospital consultation in each specialty per confinement, for each condition being treated.

You are not covered for consultations in the fields of pathology, roentgenology, or anesthesiology.

Consultations are covered only upon the direct referral and advice of your attending physician. In order for the service to be covered, the consultant must submit a report to the referring physician.

Second surgical consultations are available through NYC HEALTHLINE. (See Section Six of this booklet and the "New York City Summary Program Description" booklet.)

11. Diagnostic Procedures, X-Ray Examinations and Laboratory Tests. You are covered for diagnostic procedures. These consist of diagnostic laboratory and X-ray procedures performed out of the hospital by a doctor or an independent laboratory. In-hospital services are covered only if billed by independent physicians, who are not hospital employees.

You are covered for the separate interpretation of X-rays and laboratory tests. A non-participating radiologist or pathologist must give you a separate bill for this service. Payment shall be made based upon 30% of the radiology or laboratory procedure allowance after your deductible has been satisfied. Under the Participating Provider Program, a $10 Co-pay Charge applies. (See Section Three, Paragraph 1.)

You are not covered for screening exams except as provided in Paragraph 2.

12. Shock Therapy. You are covered for shock therapy. It may be given in or out of the hospital. There is no annual maximum number of treatments for this benefit.

13. Ambulance Service. You are covered for emergency ambulance service. This benefit is an indemnity benefit only. It is not available as a paid-in-full benefit through Participating Providers. It is also not subject to a deductible. GHI will reimburse you at 80% of the Allowed Charge, up to a maximum of $1,000 per trip.

You are not covered for ambulette service. You are not covered for air ambulance. However air ambulance services from one hospital to another may be covered under your Blue Cross Coverage.

14. Excess Hospitalization Coverage/Inpatient Hospital Charges.

You are covered for hospital charges in excess of your Blue Cross benefits. Coverage is available only for charges described in this paragraph. GHI covers hospital services ordinarily covered by Blue Cross. Your Blue Cross deductible is not covered.

Charges for full days covered by Blue Cross are never covered by GHI. GHI covers admissions for diagnostic studies, physical therapy and medical rehabilitation. (See Paragraph 18 of this Section). These admissions may be in specialized rehabilitation facilities. You are not covered for custodial hospital care.

Coverage for Hospital Charges includes the following:

(a) Room and Board. The charge may not exceed the hospital's most common semi-private room rate.

(b) Special Hospital Services. This includes services rendered by hospital staff or other hospital employees.

(c) Drugs supplied by the hospital.

(d) Diagnostic tests performed by the hospital.

Special Limitations Applicable to Inpatient Hospital Charges Only.

(a) If you have the 75-day or the 365 day Blue Cross Program, your benefit for hospital charges is subject to the $200,000 annual maximum per person.

(b) All payments for hospital charges count towards the applicable annual and lifetime maximum and are subject to deductibles and co-insurance.

15. Outpatient Hospital Charges. You are covered for outpatient hospital charges only if the service provided is not covered by Blue Cross. The service must be rendered in an Out-Patient Department of a Hospital. The service is not covered if it is the result of an accident or a sudden or serious illness which is covered under your Blue Cross coverage. Related diagnostic X-rays, laboratory tests and charges by physicians who are not hospital employees are covered.

16. Hemodialysis Service. You are covered for hemodialysis service. However, please see Section Fourteen, Paragraph 1(c), for limitations concerning individuals with End-Stage Renal Disease.

17. Centers of Specialized Care. You may be eligible for paid-in-full benefits for select cardiac procedures and heart transplants under the GHI Centers of Specialized Care Program. The GHI Centers of Specialized Care Program is a network of hospitals designed to offer you paid in full hospital and medical benefits for select cardiac tests and surgeries and heart transplants.

This Program is available to you only if you are:

(a) an active employee;

(b) a non-Medicare eligible retiree; or

(c) a covered dependent of an active employee or a non-Medicare eligible retiree.

You must also have your primary insurance coverage through the City of New York in order to be eligible to participate in this Program.

(a) **Paid-in-Full-Benefits.** Hospitals and physicians who participate in the GHI Centers of Specialized Care network have agreed to accept GHI's payment as payment in full for the cardiac and heart transplant procedures covered under the Program. When you choose a network hospital, you incur no out of pocket expenses for covered cardiac or heart transplant procedures. Also, your hospital deductible is waived. If you choose to receive services outside of the network, your care will be covered under your standard GHI/CBP/ Empire Blue Cross Blue Shield Plans. Accordingly, your benefits will be subject to the deductibles and maxima that normally apply to your coverage.

(b) **Access to the Program.** You must call NYC HEATHLINE at 1-800-521-9574 in order to participate in the GHI Centers of Specialized Care Program. Only certain cardiac services are covered under this Program. As such, you should call NYC HEATHLINE as soon as possible after you learn that you need cardiac care. For example:

- If cardiac surgery may be necessary, and you are referred to a cardiologist for tests, call NYC HEATHLINE if you wish to have the tests provided through the network.
- If cardiac surgery is necessary, and your physician refers you to a heart surgeon, call NYC HEATHLINE if you wish to have the surgery provided through the network. All admissions under the GHI Centers of Specialized Care Program must be precertified. Call at least 10 days prior to your admission to maximize your benefits and avoid penalties. NYC HEATHLINE will refer your case to GHI. A GHI nurse consultant will answer your questions. He or she will also coordinate the arrangements for your care. If you wish, you may contact GHI directly by calling 1-800-223-9870.

(c) **Limitations.** The GHI Centers of Specialized Care Program covers cardiac care only. Any in-hospital medical care and other services provided to you in a network hospital during your stay which are not incidental to your cardiac procedure or heart transplant will not be covered as part of the GHI Centers of Specialized Care Program. They will be covered under your standard GHI/CBP/Empire Blue Cross Blue Shield Plans. Coverage for such care and services will be subject to the deductibles, co-insurance and maxima applicable to your standard plan. As with all planned hospital admissions, you must precertify your admission to a GHI Centers of Specialized Care network hospital with NYC HEATHLINE.

18. Hospital Admissions Primarily for Physical Therapy, Physical Rehabilitation or Physical Medicine. You are covered for up to 30 days per calendar year for hospital stays the primary purpose of which is physical therapy, physical medicine, physical rehabilitation, or a combination of these services. Coverage may be extended beyond 30 days if authorized (through GHI or NYC HEATHLINE) based on medical necessity. Coverage for these services is subject to the deductibles and maxima set forth in Section Four.

19. Diabetes Management. You are covered for equipment and supplies for the treatment of diabetes. You are also covered diabetes self-management education. Your coverage is described below.

(a) **Equipment and Supplies**. You are covered for certain equipment and supplies for the treatment of diabetes. In order to be covered,

a Provider must recommend or prescribe the equipment and supplies. The Provider must be legally authorized to write a prescription. You are covered for the items described in this paragraph. The Commissioner of the New York State Department of Health may provide and periodically update by rule or regulation a list of additional diabetes equipment and related supplies such as are medically necessary for the treatment of diabetes. Such additional equipment and supplies are also covered.

You are covered for the equipment set forth below.

(1) Blood glucose monitors. This includes blood glucose monitors for the legally blind.

(2) Data management systems.

(3) Test strips for glucose monitors and visual reading and urine testing strips.

(4) Injection aids.

(5) Cartridges for the legally blind.

(6) Insulin pumps and appurtenances thereto.

(7) Insulin infusion devices.

The equipment listed above is covered in full if you obtain it from a GHI Preferred Provider of durable medical equipment (DME). If you obtain it from a provider who is not a Preferred Provider, it is covered subject to the deductible and maxima set forth in Section Four. For the names of GHI DME Preferred Providers, please call (212) 501-4GHI. (See also Paragraph 24 of this Section).

You are also covered for the items set forth below.

(1) Insulin.

(2) Needles and Syringes.

(3) Oral agents for controlling blood sugar.

If you are covered under an Optional Rider to this Plan, these items are reimbursed according to the terms of your Optional Rider. They are not reimbursed according to the terms of this paragraph. Please refer to your Optional Rider for a description of your benefits and for instructions for filing of claim forms.

If you are not covered under an Optional Rider to this Plan, these items are covered under this paragraph. You are subject to a $5 Co-pay Charge for these items. They are not available from Participating Providers. You must pay the full cost for these items. You must obtain a receipt for your purchase. You must submit a claim form to GHI. GHI will reimburse you directly. You will be paid in full for these items, less the $5 Co-Co-Pay Charge.

(b) **Education**. You are also covered for diabetes self-management education. This includes education relating to proper diet. Diabetes self-management education ensures that persons with diabetes are informed as to the proper self-management and treatment of their diabetic condition. It is covered only if it is conducted by a Provider. The Provider must be legally authorized to write a prescription. It may also be provided by a member of the Provider's staff. It must be part of an office visit for diabetes diagnosis or treatment. It is covered only in the instances set forth below.

(1) Upon the diagnosis of diabetes.

(2) Upon a physician's diagnosis of a significant change in symptoms or conditions which require changes in self management.

(3) Where reeducation or refresher education is necessary.

Diabetes self-management education may also be conducted by one of the following:

(1) A certified diabetes nurse educator.

(2) A certified nutritionist.

(3) A certified or registered dietician.

In order to be covered, you must be referred by a Provider. The Provider must be authorized to write a prescription. The education must be provided in a group setting if practicable. A home visit is covered only if it is medically necessary.

Diabetes self management education is covered according to the terms of Sections Three and Four.

20. Preventive and Primary Care Services for Dependent Children. Your covered dependent child is covered for preventive and primary care services as described below from birth until age 19. The services must be provided by or under the supervision of a Provider set forth below.

- A physician.
- A licensed nurse practitioner eligible for reimbursement by law.

The services must be performed in the Provider's office or in a hospital as defined in Section 2801 of the Public Health Law.

The services described below are not subject to a Co-pay Charge when rendered by a Participating Provider.

(a) **Initial In-Hospital Pediatric Visit**. You are covered for an initial in-hospital well-baby visit for your newborn in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

(b) **Well Child Visits**. You are covered for well child visits scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Each visit shall include services in accordance with these prevailing clinical standards.including:

1. Medical history.
2. Complete physical examination.
3. Developmental assessment.
4. Anticipatory guidance.
5. Appropriate immunizations and laboratory tests. These must be ordered at the time of the visit. They must be performed in the Provider's office or in a clinical laboratory.

(c) **Necessary immunizations**. Coverage is provided for necessary immunizations as determined by the New York State Superintendent of Insurance in consultation with the New York State Commissioner of Health. These consist of at least adequate dosages of vaccine against the diseases set forth below. The dosages of vaccine must meet standards approved by the United States Public Health Service for such biological products.

a. Diphtheria.
b. Pertussis.
c. Tetanus.
d. Polio.
e. Haemophilus influenza type b.
f. Measles.
g. Mumps.
h. Rubella.
i. Hepatitus b.

21. Home Care Services. You are covered for home care services. The extent of your coverage is described below. In order to be eligible for paid-in-full benefits, the home care services must be precertified with GHI Coordinated Care and rendered by a GHI participating home care agency.

(a) **Type of Home Care Agency Covered.** GHI will pay for home care visits made by a Certified Home Care Agency. The Agency must have an Operating Certificate to provide home care issued under Article 36 of the New York State Public Health Law. Payment will not be made for care rendered by a licensed home care agency unless the home care agency has an Operating Certificate under Article 36.

(b) **Conditions for Home Care Coverage.** GHI will pay for Home Care visits only if the following conditions are met.

(i) If you had not received Home Care visits, you would have had to have been hospitalized or cared for in a Skilled Nursing Facility. The Home Care visits must be a substitution for hospital care or care in a Skilled Nursing Facility.

(ii) Home Care services must commence no later than 21 days following:

- your discharge from the hospital; or

- the onset of the condition requiring your confinement.

(iii) A plan for your Home Care must have been established and approved in writing by a physician.

(c) **Covered Home Care Services.** You are covered for the following Home Care services provided by a Certified Home Care Agency.

(i) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).

(ii) Part-time or intermittent home health aide services which consist primarily of caring for the patient.

(iii) Medical social worker visits.

(iv) Physical, occupational, or speech therapy if the Home Care Agency provides these services.

(v) Laboratory services, X-rays and EKG services provided by or on behalf of the Home Care Agency.

(vi) Drugs prescribed by a physician when dispensed by a certified home health agency.

(vii) Ambulance or ambulette to or from the nearest hospital if medically necessary. Medical supplies are covered only when provided by a GHI Preferred Provider of durable medical equipment (DME). They must be prescribed by a doctor.

(d) **Extent of Coverage.** The extent of your coverage varies. It depends upon whether you receive services from a GHI participating home care services provider or any other eligible home care services provider.

(i) **Participating Provider.** If you receive covered services from a GHI participating home care services provider, you are covered in full for up to 200 home care visits per person per calendar year. You must precertify the home care services with GHI Coordinated Care by calling:

- in New York City (212) 615-4662;
- outside New York City 1-800-223-9870.

Home care services are subject to concurrent review by GHI Coordinated Care. For the names of GHI participating home care services providers in your area, please call GHI Coordinated Care.

If you are outside of GHI's home care services participating provider operating area and cannot use a participating provider, please contact GHI Coordinated Care. If you pre-certify out-of-area services with GHI Coordinated Care, you are eligible for coverage of up to 200 home care visits per person per calendar year. GHI will pay you up to 100% of the average payment it makes to a GHI participating home care services provider for covered services. If you do not precertify the services, you are covered as set forth item (ii) below.

(ii) **Any Other Home Care Services Provider.** You are also covered for services rendered by a non-participating home care services provider. You are subject to a $50 deductible per person per episode of care. After you have met this deductible, you are covered for up to 40 visits per person per calendar year. GHI will pay you up to 80% of the average payment it makes to a GHI participating home care services provider for the type of services you receive. You must pay any difference between GHI's payment and the provider's charge.

GHI will pay for Home Care visits and for the other services listed above only for as long as you would otherwise have had to be confined in a Hospital or in a Skilled Nursing Facility.

However, GHI will not pay for more visits than set forth in paragraphs (i) and (ii) above in each calendar year.

Each visit by a member of a Home Care team is counted as one Home Care visit. Up to four hours of home health aide service are counted as one Home Care Visit.

22. Home Infusion Therapy. You are covered only for home infusion therapy rendered by a GHI Preferred home infusion therapy provider. Your coverage includes:

- Antibiotic Therapy.
- Hydration Therapy.
- Pain Management.

- Chemotherapy.
- Total Parenteral Nutrition (TPN).
- Aerosolized Pentamidine.

(a) **Conditions for Home Infusion Therapy Coverage.** GHI will pay for home infusion therapy only if the following conditions are met.

(i) A physician must give specific written orders authorizing home infusion therapy.

(ii) The home care infusion services are precertified with GHI Coordinated Care.

(iii) The services are rendered by a GHI participating home infusion therapy provider.

You are not covered for home infusion therapy rendered by a non-participating provider. However, the individual component services of the home infusion therapy (e.g. - private duty nursing, prescription drugs, and durable medical equipment) may be covered under other provisions of this Certificate.

If you are outside of GHI's home infusion therapy participating provider operating area and cannot use a participating provider, please contact GHI Coordinated Care.

(b) **Covered Home Infusion Therapy Services.** GHI will pay a participating home infusion therapy provider directly for the services set forth below. The services must be medically necessary and related to the home infusion therapy. The provider must supply and bill for the services.

- Supplies and equipment for the administration of home infusion therapy.
- Drugs.
- Nursing Services. This includes nursing assessment, patient education and training and nursing visits.

23. Private Duty Professional Nursing Service. You are covered for Private Duty Nursing Services. The service may be rendered at home or in a hospital. The doctor in charge of he case must file a statement acceptable to GHI that there is a medical need for the skilled nursing service. The doctor must prescribe a plan of skilled nursing care. The patient's condition must be unstable and require constant monitoring. The skilled nursing service must relate to the patient's diagnosis and condition.

An R.N. must render the service. The charges for the service must be submitted based upon the time spent by the nurse. An L.P.N. may render this service only if an R.N. was not available to render this service. A statement to that effect, acceptable to GHI, must be filed with GHI. This service is never covered when it is or could be rendered by home health aides, homemakers, housekeepers, home attendants, or similar practitioners.

If you receive these services from a GHI Participating Provider of private duty nursing services, you are covered in full. You must precertify the services with GHI Coordinated Care by calling (212) 615-4662 in New York City or 1-800-223-9870 outside New York City.

If you receive these services from a non-participating provider, you are subject to a separate $250 deductible per person per calendar year for covered private duty nursing services. After you have met this deductible, GHI will cover this service. Payment will be made at 80% of the average payment GHI makes to a GHI Participating Provider of private duty nursing services for covered services.

You are covered for private duty professional nursing services rendered by Participating and non-participating Providers up to a maximum of $100,000 per calendar year. Payments made by GHI toward private duty nursing also count toward your overall annual and lifetime maxima. You are not covered for private duty nursing services in connection with a normal delivery unless medically necessary.

Custodial care is not covered. Custodial care is care that is provided primarily for personal needs and care that can be provided by aides who have no professional skills or training. Help in walking or getting in or out of bed are examples of custodial care. Assistance in bathing, dressing, eating or orally taking medicine is also considered custodial. Custodial care is never covered even if rendered by an R.N. or L.P.N. In determining what is custodial care, GHI shall also be guided by the standards established by Medicare.

24. Durable Medical Equipment ("DME") Equipment. You are subject to a separate deductible for the rental or purchase of Durable Medical Equipment ("DME"). The deductible is $100 per person, per calendar year. Once you have met your annual DME deductible, GHI will cover this service. The extent of coverage will depend on whether you use a "Preferred Provider" or another provider.

Covered Items. You are covered for the rental, purchase and repair and maintenance (when not covered by a manufacturer's warranty or purchase agreement) of the following items of Durable Medical Equipment when medically necessary.

(a) Hospital Beds.

(b) Crutches.

(c) Walkers.

(d) Wheelchairs.

(e) Belts and trusses.

(f) Lamps and diathermy equipment.

(g) Artificial eyes, limbs and other prosthetic appliances, which replace internal body organs.

(h) Orthopedic and incontinence appliances.

(i) Oxygen and oxygen equipment.

(j) Other durable medical equipment or appliances may be covered. In order to be covered, you must submit evidence of the medical necessity of the item to GHI at the time of submission of the claim. The evidence of medically necessity must be acceptable to GHI.

The following are examples of items not covered as Durable Medical Equipment.

(a) Splints.

(b) Casts.

(c) Orthopedic or orthotic devices for the feet.

(d) Air conditioning devices.

(e) De-humidifiers.

(f) Elevator stairs.

(g) Wigs, hairplugs or other hairpieces.

(h) Intra-oral appliances and/or intra-oral orthopedic devices and their maintenance; intra-osseous devices and their maintenance.

(i) Adjustable beds or other beds which are not strictly hospital beds.

(j) Over-the-counter items, such as antiseptics, alcohol, cotton balls, gels, ointments and other similar items.

In determining what is payable, GHI will be guided by Medicare guidelines. Appliances, Equipment and Oxygen are not available as paid-in-full benefits from Participating Providers. Co-insurance charges, deductibles, and maximums are applicable to this benefit.

Certain DME items cannot be acquired through Preferred Providers, but are covered under this Certificate. They are as follows:

- Mastectomy Bras. You are covered for the purchase of two mastectomy bras per calendar year. You will be reimbursed directly by GHI at 100% of the Allowed Charge subject to the deductible for DME.
- Prosthetic devices and orthotic devices are not available through Preferred Providers. GHI will reimburse you at 80% of the allowed charge for covered prosthetic devices and orthotic devices after you have met your DME deductible.
- Syringes are covered and dispensed through your pharmacy. You must meet your DME deductible. Thereafter, then you will be reimbursed directly by GHI at 80% of the Allowed Charge

Preferred Providers. If you use a Preferred Provider for any other covered DME, GHI will reimburse the Provider in full after you have met your annual deductible for DME. Certain DME items for the treatment of diabetes are not subject to this deductible. These items are always covered in full when obtained from a Preferred Provider. These items are listed in Paragraph 19 of this Section. For the names of GHI DME Preferred Providers, please call (212) 501-4GHI.

Other Providers. If you receive DME from a provider who is not a Preferred Provider, GHI will reimburse you at 50% of the allowed charge after you have met the deductible. You are responsible for any difference between GHI's payment to you and the Provider's charge.

Certain DME items for the treatment of diabetes are subject to different payment terms. Please refer to Paragraph 19 of this Section for the list of these items and a description of your coverage.

Pre-Authorization. When the charge for DME equals or exceeds $2,000 you must receive pre-authorization from GHI. The DME supplier must call GHI's Coordinated Care Department at 1-800-223-9870 for pre-authorization of this equipment. However, you must call GHI's Coordinated Care Department at 1-800-223-9870 for pre-authorization of all prosthetic devices, orthotic devices, and infusion therapy

Maxima. Payments made for DME count toward the overall $200,000 annual and $1,000,000 lifetime maxima under the Certificate. These payments count toward the maxima if the service is provided by a Preferred Provider or by another provider.

25. The GHI-Behavioral Management Program.

You are covered under the Behavioral Management Program (BMP).

The GHI Behavioral Management Plan is a mental health and chemical dependency benefits program. It was developed with the New York City Employee Benefits Program and the City's Municipal Unions. If you are a City employee or a non-Medicare eligible City retiree, the BMP is part of your coverage. Your non-Medicare eligible dependents are also covered if you have family coverage.

The BMP helps you receive covered services at an appropriate level of care. To be eligible for full benefits, you must call the Clinical Referral Line prior to receiving covered services. The telephone number is 1-800-NYC-CITY (1-800-692-2489).

The Clinical Referral Line is staffed by trained clinicians. You may call 24 hours a day, 365 days a year. The clinicians will help you determine the best form of care. They can help you select a provider who is best suited to your needs. You may also call the Clinical Referral Line in case of an emergency. The clinician will refer you to the closest facility or emergency room.

The BMP offers a network of Participating practitioners and facilities. Except where noted, you may select a Participating or non-participating provider. You may obtain the names of Participating providers in your area by calling the Clinical Referral Line.

Participating providers must pre-certify covered services under the Plan. They may not bill you for covered services which were not pre-certified. You must pre-certify care rendered by non-participating providers. To pre-certify care, you must call the Clinical Referral Line.

BMP-COVERED OUTPATIENT TREATMENT

1. Chemical Dependency Benefits.

A. Benefits. You are covered for outpatient visits for the diagnosis and treatment of alcoholism. You are covered for outpatient visits for the diagnosis and treatment of substance abuse and dependence. The visits must take place in an approved facility for treatment. (See paragraph C below). GHI will not pay for visits in programs of a social, recreational, or companionship nature.

To be covered, each visit must consist of at least one of the services listed below.

- Individual or group counseling.
- Activity therapy.
- Diagnostic evaluations by a doctor or other licensed medical professional to determine the nature and extent of your illness or disability.

All covered services must be provided by an employee of the facility. GHI will not make any payments to an individual who provides any of the covered services. No payment will be made if the facility turns the payments over to the individual who provided the service.

B. Number of Visits Covered. You are covered for a total of 60 outpatient visits for the above services in each calendar year. There is no Co-pay Charge for such visits. GHI will pay for 1 visit per day. However, GHI will pay for a family therapy visit and an individual visit that takes place on the same day.

If you have family coverage, up to 20 of the 60 visits available to the person with the alcohol or substance abuse problem may be used for family therapy. The 20 family therapy visits are covered even if the person with the alcohol or substance abuse problem is not receiving

treatment. The family therapy visits may only be used by members of the family who are covered under this Plan. Regardless of the number of covered family members, only 20 family visits are available for the treatment of the family member with the alcohol or substance abuse problem.

Family therapy consists of visits for members of a family. The purpose of these visits is to aid in the understanding of the illness. These visits also help family members play a meaningful role in the recovery. Payment for a family therapy session will be the same as for an individual visit. This is true, regardless of the number of family members who attend the session.

C. Approved Facilities for Treatment. In New York State, the facility must be certified by the Division of Alcoholism and Alcohol Abuse or by the Division of Substance Abuse Services to provide the service.

You may receive covered treatment outside of New York State. The facility must be accredited to provide an alcohol or substance abuse treatment program by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

D. Payments. The amount of GHI's payment for outpatient services will vary. It will depend on whether the facility is a Participating or a non-participating facility.

- **Participating Facility.** A Participating Facility is an approved facility which has an agreement to provide care to covered persons. GHI will pay the facility directly. Payment will be made in full for covered services. You will not have to make any payments.
- **Non-Participating Facility.** A non-participating facility is an approved facility which does not have an agreement with GHI. GHI will pay 75% of the average payment it would have made to a Participating Facility for the kind of care you receive. GHI's payment may not fully cover the charge to you. You must pay any balance.

2. Mental Health Benefits.

A. Benefits. You are covered for outpatient psychiatric care. Psychiatric care is defined as the diagnosis or treatment of mental, nervous or emotional disorders and ailments. The BMP will use the most recent edition of the American Psychiatric Association's Diagnosis and Statistical Manual of Mental Disorders (DSM) to determine what conditions are covered. The care must be rendered by a Provider listed below.

- A physician.
- A registered or certified psychologist.
- A certified social worker. The social worker must be qualified as a Provider for third-party reimbursement under the laws of New York State. He or she must have six years of post-masters' degree supervised psychotherapy experience.

The service may be rendered in a clinic, psychiatric center or Hospital outpatient department. Payment will not be made unless the service is rendered by one of the Providers set forth above. Services which are merely supervised or directed by a such a Provider are not covered.

In order to be covered, outpatient psychiatric care must be rendered by a Participating Provider. GHI will pay a Participating Provider directly for covered services. Payment will be made in accordance with the Plan's Allowances. Each visit is subject to a $10 Co-pay Charge.

Outpatient psychiatric care is not covered when rendered by a non-participating Provider. Benefits for such services are provided only under the Optional Benefits Rider. (See below.)

B. Number of Visits Covered. You are covered for a total of 30 outpatient visits for the above services in each calendar year. Group and individuals' visits are counted as one visit.

3. Diagnostic Evaluations. You are covered for diagnostic evaluations to determine the nature and extent of your condition or illness. You are covered for a total of 5 evaluations in each calendar year. These visits do not count as part of the outpatient visits described above. To be covered, you must call the Clinical Referral Line prior to receiving care. You will be referred to a specialist.

4. Treatment Plan. All covered services must be medically necessary. A treatment plan must be pre-certified before you begin any covered outpatient treatment.

Participating Providers will pre-certify your treatment plan. Participating providers may not bill you for covered services which were not pre-certified. You must call the Clinical Referral Line to pre-certify care rendered by non-participating Providers. The telephone number is

1-800-NYC-CITY (1-800-692-2489).

All care is reviewed for medical necessity.

5. Appeals. You may appeal if your treatment plan is not approved. To appeal, call the Clinical Referral Line. Your appeal will be decided within 60 days. This is measured from the date of receipt of all necessary information from you and your Provider.

BMP-COVERED INPATIENT TREATMENT

1. Chemical Dependency Benefits.

A. Benefits. You are covered for the diagnosis and treatment of alcoholism and alcohol abuse. You are also covered for the diagnosis and treatment of substance abuse and dependence. You are also covered for detoxification. The detoxification treatment must be provided in an approved hospital or detoxification facility. (See Paragraph C below.)

Rehabilitation care is also covered. You must be confined in a Participating Facility. These services are not covered when rendered in a non-participating facility. Coverage for such services is only provided under the Optional Benefits Rider.

B. Number of Days Covered. You are covered for 30 days of active treatment in each calendar year. There is a lifetime maximum of 60 days. Visits for detoxification or rehabilitation each count as one visit.

C. Approved Facilities for Treatment. In New York State, the facility must be certified by the Division of Alcohol and Alcohol Abuse or by the Division of Substance Abuse Services to provide the treatment.

You may receive covered inpatient care outside New York State. The facility must be accredited by the JCAHO to provide alcoholism or substance abuse treatment.

D. Payments. The amount of GHI's payment for inpatient services will vary. It depends on whether you receive treatment in a Participating or non-participating facility.

- Participating Facility. A Participating facility is an approved facility which has an agreement to provide to covered persons. GHI will pay the facility directly. Payment will be made in full for covered services. You will not have to make any payments.
- Non-Participating Facility. GHI will pay for covered detoxification services rendered in an approved non-participating facility. Such a facility has no agreement with GHI. GHI will pay 100% of the average payment it makes to Participating facilities for the services. GHI's payment may not fully cover the charge to you. You must pay any balance. GHI will not pay for rehabilitation services rendered in a non-participating facility.

2. Mental Health Benefits.

A. Benefits. You are covered for inpatient psychiatric care. Your confinement must be for mental, nervous or emotional disorders. The BMP will use the most recent edition of the DSM to determine what conditions are covered.

B. Number of Days Covered. You are covered for 30 days of active treatment in each calendar year. There is no lifetime maximum for this care.

C. Payments. The amount of GHI's payment for covered services will vary. It will depend on whether you receive treatment in a Participating or non-participating facility.

- **Participating Facility.** A Participating Facility has an agreement to provide care to covered persons. GHI will pay the facility directly. Payment will be made in full for covered services. You will not have to make any payments.
- **Non-Participating Facility.** GHI will pay for covered services rendered in a non-participating facility. Such a facility has no agreement with GHI. GHI's payment may not fully cover the charge to you. You must pay any balance. GHI will pay 50% of the average payment it makes to a Participating facility for the type of service you receive. After you have paid $4,000 in coinsurance expenses for this service per person per calendar year, GHI will make payment at 100% of the average payment it makes to a Participating Facility for covered services for the balance of covered days. Care that is not pre-certified is subject to a penalty of

$1,000. In no event, however, will the penalty exceed 50% of the benefit otherwise payable.

3. Pre-Certification Procedures. To be eligible for full benefits, all inpatient care must be pre-certified by calling the Clinical Referral Line. The telephone number is 1-800-NYC-CITY (1-800-692-2489).

- If your doctor recommends confinement, your care must be pre-certified prior to the admission date.
- If you are hospitalized due to an emergency, your care must be certified within one (1) business day of the admission. If you are not medically able to call within that time, you must call as soon as you are medically able to do so. An "emergency" is a condition requiring immediate inpatient care to avoid jeopardy to the patient's life or serious impairment to the patient's bodily functions.
- Written notice will be sent within forty-eight (48) hours of the pre-certification.
- Participating providers must pre-certify your care. They may not bill you for covered services which were not pre-certified. You must pre-certify care rendered in a non-participating facility.

4. Appeals. If you fail to pre-certify inpatient care due to extenuating circumstances, you may appeal. To appeal, you must call the Clinical Referral Line. GHI will decide your appeal within 60 days. This is measured from the date of receipt of all necessary information from you and your Provider.

SECTION SIX: NYC HEALTHLINE Pre-Admission Review Program/Mandatory Second Surgical Consultation Program and Voluntary Second Surgical Consultation Program

NYC HEALTHLINE

To maintain your full insurance coverage, you must call NYC HEALTHLINE before you have certain medical or hospital services. A full description of NYC HEALTHLINE is provided in the "3 Smart Reasons" brochure. You may obtain this brochure from your employing agency, your Plan, or from the New York City Employee Benefits office. You should refer to this brochure for a description of NYC HEALTHLINE.

If you are a City employee or a non-Medicare eligible City retiree, NYC HEALTHLINE is part of your coverage. NYC HEATHLINE is also part of the coverage provided to your covered spouse and covered dependent children if this Plan provides their primary medical coverage. NYC HEALTHLINE is a managed care program that was developed by the Employee Benefits Program of the New York City Office of Labor Relations and the Municipal Labor Unions.

If you or a member of your family is scheduled for certain office surgery, any outpatient surgery at a hospital or surgi-center, or any elective, non-emergency hospital admission (surgical, maternity, medical, psychiatric, or pediatric) you must call NYC HEALTHLINE at least 10 days before the surgery or admission and within 24 hours after an emergency admission to maintain your health benefits. If you are not medically able to call NYC HEALTHLINE within 24 hours after an emergency, you must call NYC HEALTHLINE as soon as you are medically able to do so. With the help of qualified health care professionals, NYC HEALTHLINE can help you make important health care decisions in managing your treatment and getting the most for your health care dollars.

The telephone number for NYC HEALTHLINE can be found on your identification cards. The telephone number is 1-800-521-9574 NYC HEALTHLINE will help you:

(a) Make informed decisions about your own health care. In most cases, your Medical Review Specialist will approve your plan of care immediately. In other cases, alternatives may be available to you. Depending on your medical problem, you might benefit from a second surgical opinion, ambulatory surgery, pre-admission testing, or early discharge with home care. All you have to do is to remember to call NYC HEALTHLINE.

(b) Preserve your health benefits and avoid penalties. It is your responsibility to call NYC HEALTHLINE. If you go ahead with a non-emergency hospital admission or certain office procedures (see paragraph [b] in NYC HEALTHLINE Mandatory Second Surgical Consultation Program description) without first calling NYC HEALTHLINE, or fail to notify NYC HEALTHLINE within 24 hours after an emergency admission your coverage may be reduced in one of two ways. For any hospital admission, or ambulatory surgery in a hospital facility or surgi-center, your Empire Blue Cross and Blue Shield coverage will be reduced by the lesser of $250 per day or 50%, up to a maximum of $500. You will be responsible for that amount.

You must call NYC HEALTHLINE if:

(a) You are a City employee, or a City retiree who is not eligible for Medicare, or you are purchasing City coverage directly under COBRA continuation coverage; and

(b) GHI provides your primary health coverage or you are a spouse or covered dependent (under 19 years old) of a City employee or retiree and GHI provides your primary health coverage.

You must call NYC HEALTHLINE at least 10 days prior to:

(a) Any scheduled non-emergency hospital admission for you or a covered family member; or

(b) Any scheduled outpatient surgical procedure at a hospital facility or surgi-center; or

(c) Any scheduled procedure in a doctor's office as listed in paragraph (b) below;

(d) For maternity admissions, as soon as the delivery date is known; or

(e) Within 24 hours of an emergency admission (or as soon as you are medically able to call if you are not medically able to call within 24 hours). Do not call NYC regarding claims or membership issues. (For questions about medical claims or membership, see Section Nine, Paragraph 3).

NEW YORK CITY HEALTHLINE MANDATORY SECOND SURGICAL CONSULTATION PROGRAM

(a) **General.** The surgical procedures listed below REQUIRE a second surgical opinion. This second opinion must be obtained through NYC HEALTHLINE. Your failure to obtain a mandatory second surgical opinion will result in diminished benefits. The second opinion must be obtained in order to avoid a reduction in your benefits. All expenses related to the listed surgical procedures are subject to a reduction if you fail to obtain the mandatory second surgical opinion. The failure of a covered individual to obtain a second opinion shall result in reduced benefits, as outlined below. Please note that if you fail to obtain the mandatory second surgical opinion, the paid-in-full feature of using a Participating Provider is no longer applicable. You must pay the Provider directly and file a claim with GHI. Payment will be made in accordance with the CBP Schedule less any applicable penalty. To arrange for your cost-free mandatory second surgical opinion, call 1-800-521-9574. The surgical consultant whom you see may not confirm the need for surgery. If you are undecided about whether to proceed with the surgery, you are entitled to have a third opinion completely free of charge. This third opinion, in order to be covered, must also be arranged through NYC HEALTHLINE. All Consultants will be Specialists. The Specialist will provide an independent opinion. However, he or she has agreed not to treat you or to perform the surgery for the procedure in question. You may fail to obtain a second opinion for one of the listed services, but believe your failure was due to extenuating circumstances. If this is the case, you may appeal for special consideration of your case. This appeal should be addressed to NYC HEALTHLINE. The decision will be made on your appeal within 30 days of receipt of all the complete and necessary information from your Provider.

(b) **Services Requiring a Second Surgical Consultation.** The following elective surgical procedures shall require a second surgical consultation:

1. Surgery of the foot.
2. Surgery of the nose.
3. Surgery of the eye.
4. Surgery of the tonsils.
5. Surgery of the adenoids.
6. Surgery of the knee.
7. Surgery of the breast.
8. Surgery to correct a hernia.

(c) **Penalties.** *If you fail to obtain the required second surgical opinion for a service listed above, your benefits in excess of the deductible shall be reduced by 50% up to a maximum of $500. Please note that if you fail to obtain the mandatory second surgical opinion, the paid-in-full feature of using a Participating Provider is no longer applicable.* If you have a second surgical opinion, you shall receive full benefits regardless of whether or not the consultant confirmed the need for the surgery. The choice of whether or not to have the surgery shall always be yours. In order to be covered, however, the surgery must be medically necessary.

REMEMBER THESE IMPORTANT NYC HEALTHLINE TIPS

(a) You do not have to call NYC HEALTHLINE if the City policyholder has Medicare or primary coverage elsewhere or is a covered dependent student.

(b) If you are required to get a second surgical opinion (see above), you must get it from one of the specialists recommended by your Medical Review Specialist at no cost to you.

PENALTY APPEAL PROCESS FOR NYC HEALTHLINE

(a) If benefits are reduced by your health plan, you will receive a letter advising you of the reduction. This letter contains information and instructions regarding appeals. To submit an appeal you must sign the letter and provide documentation or an explanation of why you feel benefits should be restored.

(b) If NYC HEALTHLINE agrees that benefits should be restored, you will be notified and the claim will be adjusted accordingly. If NYC HEALTHLINE disagrees, you will receive a letter advising you that if you wish to appeal further, it would be through the New York City Employee Benefits Program.

(c) If the Employee Benefits Program agrees that benefits should be restored, you will be notified and the claim will be adjusted accordingly. If they disagree, you will receive a letter advising you that if you wish to appeal further, it would be through your health plan. If the penalty is for a hospital admission your final appeal would be to Empire Blue Cross. If your penalty is for medical/surgical services in a physician's office your final appeal would be to GHI. The appeal to the health plan is the final step in the appeal process. If it is agreed that benefits should be restored, you will be notified and the claim will be adjusted accordingly. If the appeal is denied, you will receive a letter advising that the penalty remains your responsibility.

OPTIONAL SECOND SURGICAL CONSULTATION PROGRAM

If your doctor tells you that you need surgery, you may wish to have the need for the surgery confirmed. Certain procedures require a second surgical opinion. See Mandatory Second Surgical Opinion Program above.

Your benefits include the GHI Second Surgical Consultation Program. The surgery must be of non-emergency nature and must require hospitalization. By using this program, you will be better able to determine whether surgery is necessary and if there are other methods of treatment available to you. You may secure a second opinion directly through GHI at no cost to you.

1. How the Program Works. If your doctor tells you surgery is required, you may obtain a voluntary second surgical opinion through the GHI Second Surgical Consultation by calling (212) 615-0943. You will be asked for your Certificate, Category, and Group Numbers. These numbers are listed on your GHI Identification Card.

A form enabling GHI to obtain your medical reports will be sent to you. Please sign and return it to GHI without delay. Where possible, GHI will furnish you with the names of two or more consultants participating in the Program. You must then arrange an appointment with the consultant you select. You must telephone GHI's Coordinated Care Department at (212) 615-4662 in New York City or 1-800-223-9870 outside of New York City and notify GHI of your selected consultant and date of appointment.

Program benefits are provided without cost to you. It is not necessary to complete a Claim Form for the service or for any diagnostic tests the consultant may order. Following the examination the consultant will discuss his or her recommendation with you. A copy of the report will be sent to your primary doctor. The surgical consultant whom you see may not confirm the need for surgery. If so, and if you are undecided about the procedure, you are entitled to a third opinion through the program at no cost to you. The final decision about whether or not to undergo surgery is yours.

If you wish to obtain a voluntary second surgical opinion through NYC HEALTHLINE, you may call 1-800-521-9574.

2. The Consultants. Consultants on the GHI panel are Board Certified. They are usually affiliated with medical schools and teaching hospitals. In order that complete objectivity be maintained they have agreed under this Program not to perform the actual surgery, when required, or to treat the patient.

3. Principal Limitations and Exclusions under the Second Surgical Consultation Program. The Program does not cover all types of surgery. It does not cover emergency surgery, in-hospital consultations, or out-of-hospital surgery. Workers' Compensation cases are not covered.

Hospital admissions for diagnostic procedures such as a biopsy or cystoscopy are not covered. Cases where a prior second surgical consultation has been received under any other program are not covered under this Plan.

SECTION SEVEN: Principal Limitations and Exclusions

Benefits are not available for the following:

l. Eye and Hearing Care. Payment will not be made for eyeglasses, contact lenses (except post-cataract lenses) or hearing aids. Neither will payments be made for routine eye examinations or for examinations for the prescription or fitting of the above items.

2. Cosmetic Surgery and Treatment. Payment will not be made for services in connection with elective cosmetic surgery or treatment which is primarily intended to improve your appearance. However, payment will be made for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the part of the body involved. Payment will also be made for reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect.

3. Dental Services. Payment will not be made except as provided in Section Five, Paragraph 4. Please note that you are covered for treatment rendered within one year of the date of an accident for the repair of an injury to natural teeth which was sustained accidentally.

4. Preventive Care. Payment will not be made for certain Preventive Care services. See Section Five, Paragraph 2.

5. Workers' Compensation. Payment will not be made for care for any injury, condition or disease if payment is available to you under a Workers' Compensation law or similar legislation. GHI will not make any payments even if you do not claim benefits you are entitled to receive under the Workers' Compensation Law. Also, payment will not be made even if you bring a lawsuit against the person who caused the injury or condition. Payment will not be made even if you receive money from that lawsuit and you have repaid the Hospital or other Provider.

6. Services Covered by Government. Except for Medicaid, payment will not be made for services covered even in part, under the laws of the United States or any State or Municipality. Payment will not be made for service related-injuries or conditions provided in a Veteran Affairs facility.

7. War. Payment will not be made for services for care of illness or injury due to war, declared or undeclared.

8. Care Furnished Without Charge. Payment will not be made for any care if the care is furnished or would normally be furnished to you without charge. You are not covered for services rendered for which no legally enforceable charge is incurred.

9. Medicare. If you are eligible for Medicare, the benefits described in this booklet may not be available to you. See Section Fourteen for a description of your benefits.

10. No-Fault Automobile Insurance. Payment will not be made for any service for which mandatory automobile no-fault benefits are recovered or recoverable.

11. Experimental Treatment and Treatment Not Conforming to Accepted Medical Standards. Payment will not be made for treatment considered to be experimental according to GHI's criteria for experimental treatment. All services must conform to accepted standards of medical or psychiatric practice. Services received which are beyond the scope of the license of the person rendering the service are not covered.

12. Services Through Your Employer, Union, or Welfare Fund. You are not covered for services rendered in a hospital, department or clinic run by your employer, labor union or welfare fund for which there is no charge.

13. Excessive Care. Payment will not be made for medical services in excess of those services normally required for the treatment of a

condition.

14. Services Not Listed or Not Performed. Payment will not be made for services which are not listed in this booklet as being covered or which are not actually performed.

15. Prescription Drugs. Payment will not be made for prescription drugs, unless you have the Optional Rider.

16. Out-of-Hospital Psychiatric Care. Payment will not be made for Out-of-Hospital Psychiatric Care, except as specifically provided herein.

17. Nutritionists and Related Services. Except as specifically set forth in this Certificate, you are not covered for the services of nutritionists or for special dietary products. You are not covered for weight counseling performed by any Provider other than a covered licensed Provider. Weight control treatment provided by a medical doctor must be deemed medically necessary in order to be covered.

18. Occupational Therapy. Payment will not be made for occupational therapy except as part of the home care services benefit. (See Section Five, Paragraph 21.) Physical therapy rendered by a licensed occupational therapist is covered.

19. Convalescent or Custodial Care. You are not covered for services related to bed rest, rest cures, convalescent care, or custodial care. You are not covered for sanitarium care. You are not covered for care in a nursing home.

20. Educational or Vocational Services. You are not covered for services which are either educational or vocational in nature.

21. Mandatory Second Surgical Opinion. In order to receive full benefits, you must in certain cases have a second surgical opinion. See NYC HEALTHLINE Section Six for details.

22. Medical Summaries. You are not covered for Medical Summaries and/or medical invoice preparation.

23. Alcoholism and Substance Abuse. You are not covered for services for alcoholism or substance abuse, except as specifically provided herein.

24. Duplicate Services. You are not covered for duplicate services actually provided by both a certified nurse-midwife and a physician.

25. Routine Podiatric Services. You are not covered for routine podiatric care. This refers to the services set forth below rendered in connection with the routine care of the feet.

(a) Orthopedic shoes and other supportive devices.

(b) Services or supplies for the treatment of the following unless open surgery is necessary:

- (i) Weak feet.
- (ii) Strained feet.
- (iii) Flat feet.
- (iv) Any instability or imbalance of the feet.
- (v) Metatarsalgia (pain in the sole of the foot in the region of the arch).
- (vi) Bunions.

(c) Services or supplies for the treatment of any of the following services, except when the treatment is prescribed for a metabolic disease:

- (i) Corns.
- (ii) Calluses.
- (ii) Toenails.

26. Stand-by Services. You are not covered for stand-by services. Stand-by services are services that a Provider performs relating to being available to provide services on a contingent basis. Mere standing by is not covered. Stand-by services may be deemed to be rendered by any Provider.

Listed below are examples of two types of stand-by services.

Example One. The administration of anesthesia is not a stand-by service. It is a covered service. The services listed below when rendered by an anesthesiologist are not covered. They are deemed "stand-by services."

(a) Preparing a contingency anesthesia plan.

(b) Merely being in the operating area.

(c) Merely being in the Hospital.

(d) Being available for diagnosis or treatment on a contingent basis if needed.

Example Two. Stand-by services may also be provided by a surgeon. Surgery or assisting at surgery are not stand-by services. They are covered services. The services listed below when performed by a surgeon are not covered. They are deemed "stand-by services."

(a) Preparing a contingency surgery plan.

(b) Merely reviewing a patient's chart.

(c) Merely being in the operating area.

(d) Merely being in the Hospital.

(e) Merely being available for diagnosis, treatment or surgery on a contingent basis if needed.

27. Prohibited Referrals. You are not covered for clinical laboratory services, X-ray or imaging services, pharmacy services or other services provided pursuant to a referral prohibited by Section 238-a(1) of the New York State Public Health Law. This law prohibits a Provider from referring patients to a practitioner or facility for these services when the Provider or a member of the Provider's immediate family has a financial relationship with the practitioner or facility. It also prohibits the Provider, the practitioner and the facility for billing or filing an insurance claim in connection with such services.

SECTION EIGHT: Coordination of Benefits (COB)

1. General. You may be covered by two or more group health benefit plans. These plans may provide similar benefits. Should you have services covered by more than one plan, GHI will coordinate benefit payments with the other plan. In this case, one plan pays its full benefit as a primary benefit. The other plan pays secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a Provider's charge.

In order to determine which plan is primary, certain rules have been established. GHI follows these rules. These rules apply whether or not you make a claim under both plans.

If GHI pays you more than you should have been paid under this provision, it has the right to recover the overpayment. GHI may recover the overpayment from you or any other person, insurance company, or other organization which gained from the overpayment. You must help GHI in recovering any overpayment. This help may mean filing claim forms with another company. It may mean endorsing checks over to GHI.

GHI has the right to decide which facts it needs in order to coordinate benefits. GHI may get needed facts from or give needed facts to any organization or person. GHI need not tell or obtain the consent of any person to do this, except as required by Article 25 of the New York General Business Law. You must give GHI any facts it needs to process a claim and coordinate benefits.

2. Definition of Plan. A plan is a form of group coverage other than Medicaid on which these rules of coordination of benefits are allowed.

A plan may include:

(a) Group insurance, group or group remittance subscriber certificates.

(b) Uninsured group coverage.

(c) Prepayment group coverage including HMOs, group practice and individual practice plans.

(d) Blanket contracts, except blanket school accident coverages or such coverages issued to a substantially similar group, where the policy holder pays the premium.

(e) The medical benefits coverage in group and individual mandatory automobile no-fault contracts.

3. Rules of Coordination. The rules for determining primary and secondary benefits are as follows:

(a) The plan covering you as an employee is primary before a plan covering you as a dependent.

(b) The plan of a parent whose birthday occurs first in the year is primary for dependent children covered under plans maintained by both parents. Birthday refers only to the month and day on which the parent is born and not the year. If both parents have the same birthday, the plan covering you the longer time is primary. If the other plan does not have the rule set forth above, but has a rule based upon the gender of the parent, that plan's rule will determine the order of benefits.

(c) If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, shall be secondary and the plan covering you as an active employee or a dependent of an active employee shall be primary as long as the other plan has a COB provision similar to this one.

4. Special Rules for Dependents of Separated or Divorced Parents.

(a) If there is a court decree that imposes financial responsibility for the health care expenses of the dependent child on one parent, that parent's plan is primary. That plan must have actual knowledge of the decree. GHI has the right to request a copy of the portion of the decree pertaining to the health care expenses of the dependent child.

(b) If there is no court decree, the plan covering the parent with custody of a dependent child is primary.

(c) If there is no court decree and the parent with custody of a dependent child remarries, that parent's plan is primary. The step-parent's plan is secondary. The plan covering the parent without custody is tertiary.

5. Payment of Benefits.

(a) When GHI is the primary plan, GHI will pay its full benefits. The other plan will pay secondary benefits.

(b) When GHI is deemed secondary, GHI will reduce its benefits so that the combined payment or benefit from all plans are not more than the actual charge for the covered service. Please note that GHI will never pay more than its full benefits as a secondary plan, even if the benefits or payments of the combined plans are less than 100% of charges.

6. Plans with Different COB Rules. Group plans are written in many states. Not all states or groups follow the same rules. Some plans have language that states that the plan is an "excess" plan or is "always secondary". In that event, GHI will coordinate as follows:

(a) If GHI would be primary under the rules listed above, it will pay primary benefits.

(b) If GHI would be secondary under the rules listed above, it will pay its benefits first. However, the amount of benefits paid will be determined as if GHI was the secondary plan. Such payment will be the limit of GHI's liability.

(c) In order to determine benefits under (b), GHI may need information from the other plan. If that plan does not provide the information necessary for GHI to determine benefits within 30 days of a request to do so, GHI will assume the benefits of the other plan are identical to GHI's. Benefits will then be paid accordingly. Adjustments will be made if information becomes available as to the benefits of the other plan.

SECTION NINE: Filing of Claims

1. How To File a Claim. Claims must be filed directly with GHI by you or your Provider. They must be filed within the time limits described below. In order to expedite processing, claims should be submitted on the appropriate GHI claim form. Participating Providers will have a supply of claim forms. You should complete the subscriber portion of the form at the time the services are rendered. The Provider should complete the Provider's portion of the form and mail the form to GHI. If the Provider's charges have been paid or if the Provider is not a Participating Provider, GHI will forward its payment directly to you.

Non-Medical claims should be filed with GHI on the appropriate GHI claim form. Non-Medical claims are Private Duty Skilled Nursing and Durable Medical Equipment. Payment of these claims shall be made directly to you.

Psychiatric claims under the Optional Rider should be filed with GHI on claim form number 2074. All information requested by GHI must be supplied in order to process a psychiatric claim. Payment of these claims shall be made directly to you.

2. When To File a Claim. In order to receive benefits you must promptly complete and file your claim form. You must file your form with GHI within 180 days after the end of the calendar year in which the services were rendered. If you fail to file your claim on time, GHI may still pay the claim if it was not reasonably possible for you to have filed your claim on time. You must file your claim as soon as it becomes reasonably possible to do so.

3. Telephone Inquiry and Claims Mailing. For information on specific claims, enrollment and general information, call: (212) 501-4GHI, Florida residents may call (800) 358-5500

For additional names of Participating Physicians or for Physicians in other areas, call: (212) 501-4GHI

Mail written inquiries and claim forms to:

GHI
P.O. Box 300
New York, NY 10116-300

SECTION TEN: Termination of Coverage

1. Termination. Your coverage under this Certificate terminates in the event of any of the following:

(a) You are no longer eligible for benefits. (Check your Health Benefits Summary Program Description booklet on eligibility for the specific rules.) Examples of loss of eligibility would include termination of employment, divorce, death of a spouse or a dependent child reaching the age limitation.

(b) The Group Contract between the City of New York and GHI is terminated.

(c) By operation of law. You will be notified as required by law.

If your coverage terminates because of loss of eligibility or termination of the Group Contract, you may purchase a direct payment contract from GHI. The conversion privilege is available to the former spouse of a member upon divorce or annulment of the marriage of the member. It is also available to the surviving spouse and other dependents covered under this Certificate upon the death of the member. The conversion privilege is available to a dependent who is no longer within the definition of family under the Certificate.

2. Benefits after Termination. When your coverage terminates benefits are available only for the following:

(a) If you are receiving In-Hospital Medical Care at the time of termination, you shall remain covered for the service until you leave the Hospital. If you enter a Hospital within 31 days after termination, you remain covered for this service, as long as you are admitted for a condition that existed at the time of termination.

(b) Surgery and related covered services are covered for 31 days after termination. The condition requiring surgery must have been in existence at the date of termination.

(c) If on the date of termination you are totally disabled as a result of an injury, pregnancy or illness, you remain covered, with respect to that disability only, up to a maximum of 18 additional months. This extension is not available, if coverage is afforded for the total disability under another group plan. You must be totally disabled as determined by GHI.

If you believe you are totally disabled and entitled to benefits please write to GHI at:

Group Health Incorporated
P.O. Box 1701
New York, NY 10023-9476

SECTION ELEVEN: Continuation of Coverage

1. Continuation of Coverage. For the purpose of this Section, a Group Member is defined as an employee or retiree to whom coverage is made available. Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), continuation of current group benefits may be available after loss of eligibility for coverage. Group Subscribers, their spouses and their dependent children may be eligible for continuation. In order to qualify for continuation of coverage, you must no longer be eligible for health care benefits because of any of the following qualifying events:

(a) Termination of employment.

(b) A decrease in benefits due to a reduction in hours of employment.

(c) Loss of coverage because of a divorce, legal separation, or the death of the Group Member.

(d) Loss of eligibility for coverage as a dependent of a Group Member.

(e) Loss of coverage of the spouse and dependents when a covered employee or a covered retiree becomes entitled to Medicare.

(f) Loss of eligibility for coverage as a covered retiree or covered spouse, dependent, or widow of a retiree whose employer filed for bankruptcy on or after July 1, 1986.

This coverage is available without evidence of insurability. Continuation is not available for certain non-resident aliens. However, these non-resident aliens may be entitled to a continuation of coverage as provided under New York State law. See Paragraph 2 below. If you have a question regarding your status for eligibility to continue coverage under Federal law, kindly contact your group.

Continuation coverage is subject to the following conditions:

(a) COBRA continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. COBRA continuation of coverage is also not available if you become covered by another group policy which provides similar benefits, unless that policy contains a pre-existing condition limitation. COBRA continuation of coverage is also not available if the reason for termination of employment was gross misconduct. However, if you were terminated due to gross misconduct you may be entitled to a continuation of coverage as provided under New York State law. See Paragraph 2 below.

(b) A Group Member, spouse, or dependent child must notify the Plan of a divorce, legal separation, or change in dependent status. This notice must be sent to the Plan within 60 days of the later of either of the following:

  (i) The date of the qualifying event.

  (ii) The date coverage would otherwise be lost.

(c) You must request continuation of coverage in writing within 60 days of the later of either of the following:

  (i) The date your coverage would otherwise terminate under your group Plan.

  (ii) The date notice of your right to continue coverage is sent to you.

(d) You must pay your group contract holder 102% of the group rate for continuation of coverage. The required premium includes 2% of the group rate to cover administration costs. If you are disabled and extend coverage from 18 to 29 months, you must pay a different premium for the 19th through 29th month. You must pay your group contract holder 150% of the group rate for the continuation of coverage. This premium may be collected on a monthly basis.

(e) Your continuation of coverage will terminate on the first of the following dates:

  (i) You become eligible for Medicare.

  (ii) You become covered under another group health care plan as an employee or dependent, unless that plan contains a pre-existing condition limitation and you had a break in coverage of more than 63 days.

  (iii) 18 months, if the qualifying event is termination of employment or reduction of hours, unless you are disabled, as determined by Social Security. The 18 months will be measured from the date of the qualifying event. Your Plan may elect to measure the 18 months from the loss of coverage.

  (iv) 29 months after termination of employment or reduction of hours if you are disabled. The 29 months will be measured from the date of the qualifying event. Your plan may elect to measure the 29 months from the loss of coverage. You must be disabled as determined by Social Security. You must be disabled on the date of termination of employment or reduction of hours or

become disabled within 60 days of termination of employment. You must notify your Plan of Social Security's determination of your disability. The notice must be provided within sixty (60) days of Social Security's determination and before the end of the 18-month continuation period. If Social Security determines that you are no longer disabled, you must notify the plan administrator of this. You must notify the plan administrator of this within thirty (30) days from Social Security's final determination. If you are no longer disabled, COBRA continuation coverage may terminate earlier than 29 months.

(v) 36 months for all other qualifying events. The 36 months will be measured from the date of the qualifying event. You may elect to measure the 36 months from the loss of coverage.

(vi) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

(vii) The date on which your group plan terminates coverage with GHI. However, if the group plan is replaced by the group contract holder with similar coverage, you have the right to become covered under the other coverage for the balance of the period that you would have remained covered thereunder.

An 18-month period of continuation may be extended to a 36-month period if a second qualifying event occurs during the 18-month period. The second qualifying event must be of the type that would allow the covered Group Member or his or her dependents to continue coverage for 36 months. The 36-month period in this case will be measured from the first qualifying event. Your Plan may elect to calculate your period of continuation coverage from the date of loss of coverage instead of the date of the qualifying event. Contact your group to determine whether the group has elected this option. This option is not available if the loss of coverage occurs because a covered employee becomes entitled to Medicare. In such a case, the period of continuation coverage for the spouse and dependents begin on the date the covered employee becomes entitled to Medicare.

When your continued coverage terminates you may purchase a direct payment conversion contract from GHI. (See Section Twelve).

2. Continuation of Coverage under New York State Law. There are cases where you may lose eligibility for coverage under this Certificate but not be eligible for continuation of coverage under Federal law. If the loss of eligibility is due to termination of employment or loss of membership in the class or classes eligible for coverage, you may be entitled to continued coverage under New York State law. Continued coverage is available without evidence of insurability. If continuation is available to the Group Member under Federal law, then the New York State continuation law does not apply. The New York State law does not apply if you become eligible for coverage under Medicare or another group health policy.

The following criteria apply to New York State continuation of coverage:

(a) Continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. Continuation of coverage is also not available if you become covered or could be covered by another group policy which provides similar benefits, unless this policy contains a pre-existing condition limitation.

(b) You must request continuation of coverage in writing and submit your first premium payment within 60 days of the later of either of the following:

(i) The date your coverage would otherwise terminate under your group Plan.

(ii) The date notice of your right to continue coverage is provided to you.

(c) You must pay your group contract holder 102% of the group rate for continuation of coverage.

(d) Your continuation of coverage will terminate on the first of the following dates:

(i) You become eligible for Medicare.

(ii) You become covered under another group health care plan as an employee or dependent, unless that plan contains a pre-existing condition limitation.

(iii) 18 months, if the qualifying event is termination of employment or membership in the class or classes eligible for coverage.

(iv) 29 months after termination of employment or membership in the class or classes eligible for coverage if you are disabled. The 29 months will be measured from the date coverage would otherwise be lost. You must be disabled as determined by Social Security. You must be disabled on the date of termination of employment or membership. You must notify your Plan of Social Security's

determination of your disability. If you are no longer disabled, continuation coverage will terminate on the later of the following:

- 18 months from the date coverage would otherwise be lost.
- The month that begins more than 31 days after Social Security determines that you are no longer disabled.

(v) 36 months if you are an eligible dependent who will otherwise lose coverage due to the death of the Group Member, divorce, legal separation, change in dependent status or the Group Member becoming eligible for Medicare. The 36 months will be measured from the date coverage would otherwise be lost.

(vi) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

(vii) The date on which your group plan terminates coverage with GHI. However, if the group plan is replaced by the group contract holder with similar coverage, you have the right to become covered under the other coverage for the balance of the period that you would have remained covered thereunder. The replacement plan must provide at least the same level of benefits provided by the prior group plan, reduced by any benefits payable under that plan. The prior group plan must provide benefits to the extent of its accrued liabilities and extension of benefits.

When your continued coverage terminates, you may purchase a direct payment conversion contract from GHI. (See Section Twelve).

3. Special Provisions for Members of the Armed Forces on Active Duty. If the Group Member is a member of a reserve component of the armed forces of the United States, including the National Guard, and on active duty, you may be entitled to:

(a) supplementary continuation of current group benefits under New York State law and conversion to a direct payment contract from GHI upon termination of continued coverage (See Paragraph B below); or

(b) suspension of coverage during the period of active duty. (See Paragraph D below).

A. Eligibility. In order to be eligible for the rights set forth in this Paragraph 3, the Group must not voluntarily maintain coverage for the Group Member during the period of active duty. Also, the Group Member must have:

(a) Voluntarily or involuntarily entered active duty (other than to determine physical fitness or for training); or

(b) Had his or her active duty voluntarily or involuntarily extended. This must occur during a period when the President of the United States is authorized to order units of the ready reserve or member of a reserve component to active duty. The extended active duty must be at the request and for the convenience of the federal government; and;

(c) Served no more than four years of active duty.

B. Supplementary Continuation of Coverage. If your group does not voluntarily maintain coverage for the Group Member during the period of active duty, you are eligible for supplementary continuation of coverage under the group contract. This supplementary continuation of coverage is available without evidence of insurability.

You must apply for supplementary continuation within 60 days of being ordered to active duty. You must pay 100% of the group premium on a monthly basis.

Continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. It is also not available if you become covered by another group policy. Supplementary continuation of coverage will be terminated when the Group Member returns to civilian status. In certain circumstances, supplementary continuation may terminate earlier. Continuation of coverage will terminate earlier on the first of the following dates:

(i) You become eligible for Medicare.

(ii) You become covered under another group health care plan as an employee or dependent.

(iii) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

(iv) The date on which the group plan terminates coverage with GHI. However, if your group replaces the Group Contract with similar coverage, you have the right to become covered under that other coverage for the balance of the period that you would have remained covered thereunder.

(v) The Group Member has served four years of active duty.

If the Group Member dies while on active duty, supplementary continuation of coverage will terminate for the surviving spouse and covered dependents of the Group Member. In the event of divorce or annulment of the marriage to the Group Member, supplementary continuation of coverage will terminate for the former spouse. In these circumstances, the former spouse and the surviving spouse and covered dependents are eligible for conversion. (See Paragraph C below).

When the Group Member returns to civilian status and he or she is reemployed or restored to participation in the group, coverage under the group plan will be resumed. Supplementary continuation of coverage will terminate on the date that coverage under the group plan becomes effective. Coverage will not be subject to limitations, conditions, exclusions or waiting periods unless:

(a) a waiting period was imposed and had not been completed prior to the period of suspension; or

(b) the Group Member's condition arose during the period of active duty and was incurred in the line of duty.

When the Group Member returns from active duty and does not become reemployed or restored to participation in the group, the Group Member may be entitled to:

(a) continue coverage under New York State Law and purchase a direct payment conversion contract from GHI upon termination of continued coverage (See Paragraph 2 of this Section); or

(b) purchase a direct payment conversion contract from GHI. (See Section Twelve).

C. Conversion.

1. Availability. When your supplementary continuation of coverage terminates, you may purchase a direct payment contract from GHI. Conversion is available to the former spouse of a Group Member upon divorce or annulment of the marriage of the Group Member. The divorce or annulment must have occurred while the Group Member was on active duty. In addition, conversion is available to the surviving spouse and other dependents covered under the contract upon the death of the Group Member. The death must have occurred during the Group Member's active duty. Conversion is also available to a dependent who is no longer within the definition of family under the contract while the Group Member is on active duty.

2. When to Apply for the New Conversion Contract. You must apply for the new contract within 31 days of the later of the following:

(i) the date the Group Member's active duty terminated; or

(ii) the date the Group Member is discharged from the Hospital. The hospitalization must have resulted from active duty. It cannot exceed one year.

Payment of the first premium must be made at the time you apply for the direct payment contract.

D. Suspension of Coverage. If the group does not voluntarily maintain coverage for the Group Member and you do not continue your group benefits, your coverage will be suspended during the period of active duty. When the Group Member returns to participation in the group plan, coverage under the group plan will be resumed. Coverage will be retroactive to the date active duty terminated. Coverage will not be subject to limitations, conditions, exclusions or waiting periods unless:

(a) a waiting period was imposed and had not beencompleted prior to the period of suspension; or

(b) the Group Member's condition arose during the period of active duty and was incurred in the line of duty.

If the Group Member returns from active duty and does not become reemployed or restored to participation in the group, the Group Member may be entitled to:

(a) continue coverage under New York State Law and purchase a direct payment conversion contract from GHI upon termination of continued coverage (See Paragraph 2 of this Section); or

(b) purchase a direct payment conversion contract from GHI. (See Section Twelve).

4. Questions. The laws regarding continuation of benefits are complicated. If your coverage under this Certificate is terminating, you should contact your Group if you are interested in continuing your benefits.

SECTION TWELVE: Direct Payment Conversion

If your coverage terminates because of loss of eligibility or termination of the Group Contract, you may purchase a direct payment contract from GHI. The conversion privilege is available to the former spouse of a member upon divorce or annulment of the marriage of the member. The conversion privilege is available to the surviving spouse and other dependents covered under the Certificate upon the death of the member. The conversion privilege is available to a dependent who is no longer within the definition of family under the Certificate.

1. When to Apply for the New Contract. You may apply to GHI for a direct payment contract. If you are an employee and your coverage terminates, you should receive written notice from GHI which informs you of your right to purchase a direct payment contract. You must apply for the new contract within 45 days receipt of notice. However, if you do not receive a notice at all, you must apply for direct payment within 90 days after your coverage terminated. If you are a dependent and your coverage terminates because you no longer qualify under this Plan as a dependent, you will not receive a written notice. You must apply for the direct payment contract within 90 days from the date your coverage terminated. Payment of the first premium must be made at the time you apply for the direct payment contract.

2. The New Contract. The direct payment contract you receive will be the GHI Standard Conversion Contract issued to direct payment subscribers. That Contract contains benefits which are different from those listed herein. GHI will issue you a direct payment contract then being offered on a direct payment basis which provides benefits most nearly comparable to the benefits of this Plan.

SECTION THIRTEEN: Miscellaneous Provisions

1. No Assignment. You cannot assign any benefits or monies due from GHI to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or organization of your right to the services provided or your right to collect from GHI for those services.

2. Your Medical Records. In order to process your claims it may be necessary for GHI to obtain your medical records and information from hospitals, skilled nursing facilities, doctors, pharmacists or other practitioners who treated you. When you become covered you give GHI permission to obtain and use these records. The information will be kept confidential.

3. Recovery of Overpayments. If GHI pays benefits under this Plan for services incurred on your account and it is found that GHI paid more benefits than should have been paid because you were: (a) not covered; (b) the services were not covered; (c) payment was in an amount greater than that to which you are entitled under this Plan; or (d) payment was in an amount greater than that to which you are entitled because you were repaid for all or some of those expenses by another source; then GHI will have the right to a refund from you. You must return the amount of the overpayment within 60 days of GHI's request.

4. Right to Develop Guidelines. GHI reserves the right to develop or adopt standards and criteria which set forth in more detail the circumstances under which it will make payment.

5. Lawsuits. A lawsuit against GHI regarding this Certificate or Group Contract must be started within two years from the date you received the medical or hospital service for which you want GHI to pay.

6. Suits against GHI for Actions of Others. You cannot sue GHI for the actions of any person or organization which renders covered medical or hospital services to you.

7. New York Law. This Contract is in all respects governed by the laws of New York State.

8. Patient's Relationship with the Provider. Nothing in this certificate shall force a Provider to accept you as a patient. This Certificate is not meant to change the normal relationship between the provider and patient. At all times the provider's usual rules will govern the service provided to the patient. GHI cannot guarantee receipt of any particular service or accommodation.

9. Who Receives Payment Under this Plan. Payments for covered services rendered by a Participating Provider will be made directly to that Provider. If you receive covered services from a non- participating Provider GHI reserves the right to pay you or the non-participating Provider.

10. Authorization for Medicare Carriers to Submit Medical Information to GHI for Payment of Supplemental and Complementary Benefits. When you become covered under this plan, you authorize the parties listed below to provide medical information to GHI or its designee.

a. Health Care Financing Administration.

b. Medicare intermediaries.

c. Medicare carriers.

GHI must receive this information in order to:

a. process Medicare related claims; and

b. provide benefits.

These terms remain in effect until all Medicare related claims incurred by you are processed.

SECTION FOURTEEN: Medicare Eligible Coverage

1. General. Your coverage under GHI/CBP changes when you become eligible for Medicare.

A. Medicare Eligible Members. If you or any of your covered dependents are eligible for Medicare, you must enroll in Medicare (both Part A and Part B) to avoid a reduction in your benefits. If you are not eligible for Medicare this Section does not affect your benefits, as listed in this booklet. If you are eligible for Medicare by reason of age, you will receive only those benefits listed in this Section Fourteen. If you are eligible for Medicare by reason of disability, Medicare is your primary carrier. GHI is your secondary carrier and will coordinate your benefits with those provided by Medicare. However, if your are an active employee or the spouse of an active employee the special rules listed in Paragraph (B) apply to you.

B. Special Rules for Active Employees. If you are an active employee, regardless of your age, coverage for yourself and your dependents is provided under GHI/CBP as your primary plan. Medicare is your secondary plan. See Paragraph C below for special rules for subscribers with End Stage Renal Disease.

C. Special Provisions for Those with End-Stage Renal Disease. If you are disabled due to end-stage renal disease, your benefits for covered services incurred due to that disease will be paid as follows:

(a) During the first eighteen months during which you incur covered services for renal disease your benefits will be paid as follows:

(i) This Plan will be the Primary Payor, subject to Coordination of Benefits provisions of this Certificate.

(ii) Medicare will be a Secondary Payor.

(b) After the first eighteen months during which you incurred covered for renal disease your benefits will be paid as follows:

(i) Medicare will be the Primary Payor of benefits and will pay the benefits available under Medicare.

(ii) This Plan will be a Secondary Plan subject to the Coordination of Benefits provisions of this Certificate. Benefits will be paid only to the extent that benefits are not paid under Medicare. Payments will be made consistent with this Section Fourteen.

2. Benefits and Limitations.

A. Covered Services. If you receive any of the services listed below, GHI will pay 20% of the reasonable charge as determined by Medicare, after Medicare has paid 80% of the reasonable charge. You are not covered for the Medicare Part B (medical) deductible. After the deductible has been met, Medicare will pay 80% of the reasonable charge of your covered service. GHI will pay the 20% balance. In certain instances, by operation of law, Medicare may reduce its payment below 80% of the Medicare reasonable charge. If this occurs, GHI will continue to reimburse you 20% of the Medicare reasonable charge. As a result, the total combined reimbursement by Medicare and GHI may be less than 100% of the Medicare reasonable charge. Charges in excess of the reasonable and customary standard set by Medicare are not covered. These charges are your responsibility. You must first file for your Medicare benefits before filing for your GHI benefits. When filing a GHI claim, please attach the Explanation of Medicare Benefits form to your GHI Claim Form. You are subject to the same standards of coverage listed throughout this booklet. Please note that if you receive covered services from a Provider who accepts Medicare assignment or who participates with GHI, GHI will reimburse the Provider directly.

The following services are covered:

(1) Home and Office Visits (except for Chiropractic care).

(2) Surgery, Assistant Surgery, and the Administration of Anesthesia.

(3) Dental Surgery.

(4) Maternity Care.

(5) In-Hospital Medical Care.

(6) Radiation Therapy and Chemotherapy.

(7) Specialist Consultation.

(8) Diagnostic Procedures, X-ray examinationsand Laboratory Tests.

(9) Shock Therapy.

(10) Intermittent Nurse Service is your home (visiting nurse service).

Please note that routine foot care and psychiatric services are not covered. GHI does not provide coverage in those instances where Medicare denies coverage, except for services rendered outside of the United States of America.

B. Additional Covered Services. You are covered for the services listed below. You are subject to a $25 annual deductible per contract (individual or family). Thereafter, GHI will pay 80% of the Allowed Charge for private duty professional nursing service. After the deductible is met, GHI will pay 20% of the Medicare approved amount for ambulance service, durable medical equipment and oxygen. There is no lifetime maximum. However, no more than $2,500 is payable in any calendar year for the services listed below. GHI will not duplicate payments made by Medicare for any of these services.

The following services are covered under this Paragraph "B":

(1) Ambulance Service.

(2) Private Duty Professional Nursing Service.

(3) Durable Medical Equipment and Oxygen.

C. Second Surgical Consultation Program. You are eligible for the benefits listed in Section Six, Second Surgical Consultation Program. However, the requirement of NYC HEALTHLINE are not applicable.

D. Optional Rider. You are eligible to sign up for the benefits listed in the Optional Benefits Rider for Medicare Eligibles.

E. When Medicare Benefits are Not Available. Medicare does not cover services rendered outside the country. GHI covers you for these services to the same extent as if you were not eligible for Medicare. Payments will be made for services listed as covered in this booklet.

F. Standards of Coverage, Limitation and Exclusions. The standards of coverage, limitations and exclusions listed in this booklet apply to all benefits.

Optional Rider for Medicare Eligible Subscribers Covered Under Section Fourteen

1. General Information. This Rider is available to you through payroll or pension deduction. If you have elected to purchase this Rider, you are entitled to the additional benefits listed in this Rider. Your Union Welfare Fund may provide like or similar benefits. When that is the case, the benefits provided by your Welfare Fund will be covered only through your welfare fund and not under the Rider. Appropriate adjustments will be made to your pension deduction.

In determining what are like or similar benefits, GHI will be guided by the determination made by the City of New York Employee Benefits Program.

2. Hospitalization. This benefit increases your Blue Cross coverage to 365 days of full coverage. See Blue Cross booklet for details.

3. GHI Prescription Drug Coverage.

(a) **Covered Items.** You are covered for drugs which by law require a written prescription. The drugs must be dispensed by a licensed registered pharmacist. A Provider must have written the prescription. That Provider must be legally authorized to write the prescription. Payment will be made only when the drug is prescribed for your use. In addition to covered prescription drugs, you are covered for nutritional supplements for the therapeutic treatment of a condition set forth below.

(i) Phenylketonuria.

(ii) Branched chain ketonuria.

(iii) Galactosemia.

(iv) Homocystinuria.

In order to be covered, the supplement must be written on a prescription and administered under the direction of a physician.

(b) **Acute Prescription Drug Coverage.** You are subject to a prescription drug deductible of $150 per person, per calendar year up to a maximum of $450 per family. A yearly maximum of $2,500 applies to this benefit. Benefits under this paragraph will vary depending upon whether you use a GHI Participating PAID Pharmacy or any other pharmacy.

(i) **Prescription Drugs Obtained at a GHI Participating PAID Pharmacy.** If you use a GHI Participating PAID pharmacy, you must present your PAID Prescriptions I.D. Card at the time of purchase. The pharmacy will fill your prescription and credit the amount paid towards the deductible and/or charge the appropriate coinsurance. After you have met your deductible, the pharmacy will be reimbursed directly at 80% of the Allowed Charge for a generic drug or a brand name drug which does not have a generic substitute. The pharmacy will be reimbursed at 60% of the Allowed Charge for a brand name drug if a generic substitute exists. You must pay the difference between the payment made to the pharmacy and the pharmacy's charge to you. If you do not present your PAID Prescriptions I.D. Card at the time of purchase, you must pay the full cost of the prescription. You will be paid as if you had gone to any other pharmacy. (See below.) Information on the location of GHI Participating PAID Pharmacies may be obtained by calling PAID Prescriptions at 1-800-272-PAID.

(ii) **Prescription Drugs Obtained at a Pharmacy that is not a GHI Participating PAID Pharmacy.** If you use a pharmacy that is not a GHI Participating PAID Pharmacy, you must pay the full cost of the prescription. You must obtain a receipt for your purchase. You must submit a claim form. You may obtain a claim form by calling 1-800-272-PAID. Send your completed claim forms to: PAID Prescriptions, Inc. P.O. Box 6121, Fairlawn, New Jersey 07410-0999. The claim form **must** be completed by the pharmacist. Prescription receipts alone will not be accepted. After you meet the deductible, you will be reimbursed directly at 80% of the Allowed Charge for the drug. However, you will only be reimbursed at 60% of the Allowed Charge for a brand name if a generic substitute is available.

(c) **Maintenance Drug Program.** Your benefits include coverage under a Maintenance Drug Program. This Program is available only through NRx Services Inc. (NRx). A maintenance drug is one that is prescribed for a chronic condition that requires constant medication. Certain conditions require the use of prescription drugs on a day-to-day, year-round basis. The Maintenance Drug Program permits long-term prescriptions to be filled. Under this Program you may receive a supply of up to 60 consecutive days. The Program saves you time. It will also reduce paperwork. There is no need to file a claim form. When you become covered under this Program, you will receive information about how to obtain a maintenance drug. There is a $8 Co-pay Charge for generic drugs obtained through the Maintenance Drug Program. A generic drug is a drug that is marketed under its non-proprietary name after expiration of the patent of a brand name drug. You are subject to a $15 Co-pay Charge for a brand name drug. To take part in the Program, ask your doctor if a maintenance quantity is suitable for you. If so, have a doctor specify the maintenance quantity of the drug to be dispensed. For example, one per day (60 doses), two per day (120 doses). Remember, prescriptions should always be sent to NRx and never to GHI. You may contact NRx at 1-800-445-9707.

(d) **Diabetes Management.** You are covered for the items set forth below in connection with diabetes management.

(i) Insulin.

(ii) Needles and Syringes.

(iii) Oral agents for controlling blood sugar.

Coverage of these items may vary. It will depend upon whether you receive these items from a GHI Participating PAID Pharmacy or any other pharmacy. Coverage for these items is not subject to a deductible. These items are also not subject to a maximum.

(i) GHI Participating PAID Pharmacies. When the items listed are obtained through a GHI Participating PAID Pharmacy, they are covered subject to the lesser of:

- a $5 Co-pay Charge; or
- the applicable percent coinsurance or Co-pay Charge for other prescription drugs.

You must present your PAID Prescriptions I.D. card at the time of purchase. If you do not present your PAID Prescriptions I.D. card at the time of purchase, you must pay the full cost of the prescription. You will be paid as if you had gone to any other pharmacy. (See below).

(ii) **Pharmacies that are not GHI Participating PAID Pharmacies.** If you obtain the items listed above from a pharmacy that is not a GHI Participating PAID Pharmacy, you must pay the full cost of the prescription. You must obtain a receipt for your purchase. You must submit a claim form. You will be paid directly. You will be paid the amount that would have been paid to a GHI Participating PAID Pharmacy. You must pay any difference between the payment and the pharmacy's charge to you.

(e) **Items Not Covered.** You are not covered for the following:

(1) Over-the-counter drugs which can be purchased without prescription, except insulin.

(2) Over-the-counter vitamins, minerals or food supplements, except as specifically provided above.

(3) Drugs dispensed while you are a bed patient in a hospital or other institution or dispensed while you are receiving covered Home Health Care by or on behalf of a certified home health agency.

SECTION FIFTEEN: Catastrophic Coverage

Benefits. In the event that you receive any of the covered services described below rendered by a Non-Participating Provider and incur out-of-pocket expenses in a calendar year of more than the catastrophic deductibles, GHI will then pay the catastrophic benefit.

(a) **Covered Services.** Covered services under Catastrophic Coverage include:

(i) Surgery.

(ii) Administration of Anesthesia.

(iii) Chemotherapy and Radiation Therapy.

(iv) Covered In-hospital Services.

(v) Maternity.

(b) **Catastrophic Deductible.** Benefits under this coverage do not begin until you incur, during a calendar year, more than $3,000 in out-of-pocket expenses. Out-of-pocket expenses are calculated based only upon the Allowed Charge for covered services.

(c) **Catastrophic Benefit.** After the $3,000 catastrophic deductible has been met, the benefits for the Covered Services set forth above are payable at 100% of the Allowed Charge. A $200,000 annual maximum applies for all services covered under this Certificate.

(d) **Formula.** The catastrophic coverage benefit may best be understood by the formula set forth below.

Allowed Charge for Covered Catastrophic Services
MINUS

All payments for Covered Catastrophic Services
MINUS

$3,000 Catastrophic Deductible
EQUALS

Catastrophic Benefit Payment

Optional Rider for Active Employees and Non-Medicare Eligible Retirees

1. General Information. This Rider is available to you through payroll or pension deductions. If you have elected to purchase this Rider, you are entitled to the benefits listed in this Rider. Your Union Welfare Fund may provide like or similar benefits. If this is the case, the benefits provided by your Welfare Fund will be covered only through your Welfare Fund and not under this Rider. Appropriate adjustments

will be made to your payroll or pension deductions.

In determining what are like or similar benefits, GHI willbe guided by the determination made by the City of New York Employee Benefits Program.

2. Benefits. Election of the Optional Rider entitles you to the benefits set forth below.

(a) **Enhanced Non-Participating Provider Reimbursement Schedule.** The amount you are reimbursed for services rendered by non-participating provider is enhanced for the following services:

(i) Surgery.

(ii) Administration of Anesthesia

(iii) In-hospital medical services.

(iv) Maternity.

The enhanced schedule for covered services is in aggregate approximately 165% of the New York City Non-Participating Provider Schedule.

(b) **Psychiatric Care and Chemical Dependency**. You are covered for the benefits set forth below. These benefits are provided through the GHI Behavioral Management Program (BMP). You must call the Clinical Referral Line prior to receiving covered services. The telephone number is 1-800-NYC-CITY. BMP Participating Providers must pre-certify covered services. You must pre-certify care rendered by non-participating providers. To pre-certify care, you must call the Clinical Referral Line prior to receiving services.

1. **Outpatient Mental Health Benefits.** You are covered for outpatient psychiatric care. The care may be rendered by a Participating or non-participating Provider. GHI's payments will not vary. However, if you use a Participating Provider, you are covered for charges in excess of your basic outpatient psychiatric benefits.

   GHI will pay 50% of the Plan's Allowances for each covered visit. There is a maximum payment of $30 for each visit. This maximum applies to individual and group visits. There is an overall maximum of $900 per person in each calendar year. Each covered individual is subject to a lifetime maximum of $1,800. You must pay any difference between the Provider's charge and GHI's payment.

   Psychiatric care is defined as the diagnosis or treatment of mental, nervous, or emotional disorders and ailments. In determining what is and what is not a disorder or ailment, the BMP will be guided by the American Psychiatric Association's Diagnosis and Statistical Manual of Mental Disorders, Third Edition, Revised. In order to be covered the service must be rendered by one of the following Providers:

   (i) A physician.

   (ii) A registered or certified psychologist.

   (iii) A certified social worker. The social worker must be qualified as a Provider for third-party reimbursement under the laws of New York State. He or she must have six years of post-Master Degree supervised psychotherapy experience. The service may be rendered in a clinic, psychiatric center or hospital outpatient department. If that is the case, payment will not be made unless the service is rendered by one of the Providers listed above. Services which are merely supervised or directed by one of the above Provider's are never covered. Regardless of the diagnosis or symptoms present, you are not covered for out-of-hospital psychiatric care which may be used for or credited to:

   • the earning of a degree.

   • the furtherance of one's education or training.

2. **Chemical Dependency Benefits.** You are covered for the inpatient treatment of alcoholism and substance abuse. Care must be rendered in an approved facility.The amount of GHI's payment will vary. It depends on whether you receive treatment in a participating or non-participating Facility.

   • **Participating Facility.** You are covered for an additional 30 days of active treatment in each calendar year. Your coverage includes benefits for detoxification and rehabilitation care. This is in addition to the 30 days provided under the basic plan.

There is no lifetime limit. Payment will be made in full for covered services. The facility must pre-certify your care. You will not have to make any payments.

- **Non-Participating Facility**. You are covered for up to 30 days for rehabilitation care. This is a lifetime limit. GHI will pay 75% of the average payment it makes to a Participating facility for the type of care you receive. After you have paid $1,000 in coinsurance expenses per admission, GHI will pay you at 100% of the average payment it makes to a Participating Facility for covered services. You must pay any difference between the Facility's charge and GHI's payment. You must pre-certify your care. To pre-certify, call the Clinical Referral Line. Care that is not pre-certified is subject to a $500 penalty. This is in addition to the coinsurance charge. In no event, however, will the penalty exceed 50% of the benefit otherwise payable.

(c) **Prescription Drugs.**

(i) Covered Items. You are covered for drugs which by law require a written prescription. The drugs must be dispensed by a registered licensed pharmacist. A Provider must have written the prescription. That Provider must be legally authorized to write the prescription. Payment will be made only when the drug is prescribed for your use. Insulin is covered whether or not it is dispensed by a written prescription.

In addition to covered prescription drugs, you are covered for nutritional supplements for the therapeutic treatment of a condition set forth below.

- Phenylketonuria.
- Branched chain ketonuria.
- Galactosemia.
- Homocystinuria.

In order to be covered, the supplement must be administered under the direction of a physician.

(ii) Acute Prescription Drug Coverage. You are subject to a prescription drug deductible of $150 per person, per calendar year up to a maximum of $450 per family. Benefits under this paragraph will vary depending upon whether you use a GHI Participating PAID Pharmacy or any other pharmacy.

1. **Prescription Drugs Obtained at a GHI Participating PAID Pharmacy.** If you use a GHI Participating PAID Pharmacy, you must present your PAID Prescriptions I.D. Card at the time of purchase. The pharmacy will fill your prescription and credit the amount paid towards the deductible and/or charge the appropriate coinsurance. After you have met your deductible, the pharmacy will be reimbursed directly at 80% of the Allowed Charge for a generic drug or a brand name drug which has a generic substitute. The pharmacy will be reimbursed at 60% of the Allowed Charge for a brand name drug if a generic substitute exists. You must pay the difference between the payment made to the pharmacy and the pharmacy's charge to you. If you do not present your PAID Prescriptions I.D. Card at the time of purchase, you must pay the full cost of the prescription. You will be paid as if you had gone to any other pharmacy. (See below.) Information on the location of GHI Participating PAID Pharmacies may be obtained by calling PAID Prescriptions at 1-800-272-PAID.
2. **Prescription Drugs Obtained at a Pharmacy that is not a GHI Participating PAID Pharmacy.** If you use a pharmacy that is not a GHI Participating PAID Pharmacy, you must pay the full cost of the prescription. You must obtain a receipt for your purchase. You must submit a claim form. You may obtain a claim form by calling 1-800-272-PAID. Send your completed claim forms to: PAID Prescription, Inc. P.O. Box 6121, Fairlawn, New Jersey 07410-0999. The claim form must be completed by the pharmacist. Prescription receipts alone will not be accepted. After you have meet the deductible, you will be reimbursed directly at 80% of the Allowed Charge for the drug. However, you will be reimbursed at 60% of the Allowed Charge for a brand name if a generic substitute is available.

(iii) **Maintenance Drug Program.** Your benefits include coverage under a Maintenance Drug Program. This Program is available only through NRx Services Inc. (NRx). A maintenance drug is one that is prescribed for a chronic condition that requires constant medication. Certain conditions require the use of prescription drugs on a day-to-day, year-round basis. The Maintenance Drug Program permits long-term prescriptions to be filled. Under this Program you may receive a supply of up to 60 consecutive days. The Program saves you time. It will also reduce paperwork. There is no need to file a claim form. When you become covered

under this Program, you will receive information about how to obtain a maintenance drug. There is a $8 Co-pay Charge for generic drugs obtained through the Maintenance Drug Program. A generic drug is a drug that is marketed under its non-proprietary name after expiration of the patent of a brand name drug. You are subject to a $15 Co-pay Charge for a brand name drug. To take part in the Program, ask your doctor if a maintenance quantity is suitable for you. If so, have a doctor specify the maintenance quality of the drug to be dispensed. For example, one per day (60 doses), two per day (120 doses). Remember, prescriptions should always be sent to NRx and never to GHI. You may contact NRx at 1-800-445-9707.

(iv) **Diabetes Management.** You are covered for the items set forth below in connection with diabetes management.

1. Insulin.

2. Needles and Syringes.

3. Oral agents for controlling blood sugar.

Coverage of these items may vary. It will depend upon whether you receive these items from a GHI Participating PAID or any other pharmacy. Coverage for these items is not subject to a deductible. These items are also not subject to a maximum.

(a) **GHI Participating PAID Pharmacies.** When the items listed above are obtained through a GHI Participating PAID Pharmacy, they are covered subject to the lesser of:

- a $5 Co-pay Charge; or
- the applicable percent coinsurance or Co-pay Charge for other prescription drugs.

You must present your PAID Prescriptions I.D. card at the time of purchase. If you do not present your PAID Prescriptions I.D. card at the time of purchase, you must pay the full cost of the prescription. You will be paid as if you had gone to any other pharmacy. (See below).

(b) **Pharmacies that are not GHI Participating PAID Pharmacies.** If you obtain the items listed above from a pharmacy that is not a GHI Participating PAID Pharmacy, you must pay the full cost of the prescription. You must obtain a receipt for your purchase. You must submit a claim form. You will be paid directly. You will be paid the amount that would have been paid to a GHI Participating PAID Pharmacy. You must pay any difference between the payment and the pharmacy's charge to you.

(c) **Items not Covered.** You are not covered for the following:

(1) Over-the-counter drugs which can be purchased without prescription, except insulin.

(2) Over-the-counter vitamins, minerals or food supplements, except as specifically provided above.

(3) Drugs dispensed while you are a bed patient in a hospital or other institution or dispensed while you are receiving covered Home Health Care by or on behalf of a certified home health agency.

(d) **Hospitalization.** Election of the Optional Rider extends your Blue Cross coverage to 365 days. These benefits are provided by Blue Cross.*

(e) **Dependents to Age 23.** Election of the Optional Rider extends your coverage of full-time unmarried dependent students until the end of the calendar year in which dependent reaches the age of 23.

(f) **Annual Maximum.** Election of the Optional Rider increases your annual calendar year CBP maximum benefit to $400,000 except for private duty nursing care coverage which remains subject to an annual calendar year maximum benefit of $200,000. Payments made towards private duty nursing will continue to count towards the overall annual maximum benefit.

* See your Blue Cross booklet for details.

SECTION II
Riders

GROUP HEALTH INCORPORATED ("GHI")

An EmblemHealth Company

55 Water Street

New York, New York 10041

RIDER TO AMEND GHI CERTIFICATE OF INSURANCE

This rider amends your GHI large group Certificate of Insurance ("Certificate"). It adds the new or updated terms set forth in this rider to your Certificate.

GROUP HEALTH INCORPORATED

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This rider amends your Certificate of Insurance ("Certificate"). It adds the new or updated terms set forth below to your Certificate. Wherever the Certificate is not consistent with this rider, the terms of this rider will control.

1. Protection from Surprise Bills.

A surprise bill is a bill you receive for covered services received on or after April 1, 2015 in the following circumstances:

- For services performed by a non-participating physician at a Participating Hospital or ambulatory surgical center, when:
  - A Participating physician is unavailable at the time the health care services are performed;
  - A non-participating physician performs services without your knowledge; or
  - Unforeseen medical issues or services arise at the time the health care services are performed.

  A surprise bill does not include a bill for health care services when a Participating physician is available and you elected to receive services from a non-participating physician.
- You were referred by a Participating physician to a non-participating Provider without your explicit written consent acknowledging that the referral is to a non-participating Provider and it may result in costs not covered by GHI.

You will be held harmless for any non-participating physician charges for the surprise bill that exceed your in-network co-pay charge, deductible and/or coinsurance if you assign benefits to the non-participating physician in writing. In such cases, the non-participating physician may only bill you for your in-network co-pay charge, deductible and/or coinsurance.

2. Emergency Services.

Payments Relating to Emergency Services Rendered.

The amount we pay a non-participating provider for covered services you receive in a hospital to treat an emergency condition on or after April 1, 2015 that are not payable under your hospital plan will be an amount we have negotiated with the Non-Participating Provider for the service or an amount we have determined is reasonable for the service. An emergency condition means: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

If a dispute involving a payment for physician services relating to emergency services payable by us is submitted to an independent dispute resolution entity ("IDRE"), we will pay the amount, if any, determined by the IDRE for physician services.

You are responsible for any in-network copayment, deductible or coinsurance. You will be held harmless for any non-participating provider charges that exceed your copayment, deductible or coinsurance in these circumstances

3. Utilization Review & Appeals.

A. Utilization Review.

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

All determinations that services are not Medically Necessary will be made by: 1) licensed physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages your medical condition or disease or provides the health care service under review; or 3) with respect to substance use disorder treatment, effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment.

We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, call the number on Your ID card or visit our website at www.emblemhealth.com.

B. Preauthorization Reviews.

1. If we have all the information necessary to make a determination regarding a Preauthorization review, we will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

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

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

C. Concurrent Reviews.

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your Provider will then have forty-five (45) calendar days to submit the information. We will make a determination and provide notice to you (or your designee) and your Provider, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within fifteen (15) calendar days of the end of the forty-five (45) day time period.

2. Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least twenty-four (24) hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you (or your designee) and your Provider by telephone within twenty-four (24) hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

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

3. Inpatient Substance Use Disorder Treatment Reviews. Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, if a request for inpatient substance use disorder treatment is submitted to us at least twenty-four (24) hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within twenty-four (24) hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.

D. Retrospective Reviews.

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and, if applicable, your Provider within thirty (30) calendar days of the receipt of the request. If we need additional information, we will request it within thirty (30) calendar days. You or your Provider will then have forty-five (45) calendar days to provide the information. We will make a determination and provide notice to you in writing within fifteen (15) calendar days of the earlier of our receipt of the information or the end of the forty-five (45) day period.

Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

E. Retrospective Review of Preauthorized Services.

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

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

F. Reconsideration.

If we did not attempt to consult with your Provider before making an adverse determination, your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.

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

You have up to one hundred and eighty (180) calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within fifteen (15) calendar days of receipt. This acknowledgment will if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

1. **Out-of-Network Service Denial.** Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, you also have the right to appeal the denial of a Preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating Provider, but only when the service is not available from a Participating Provider. You are not eligible for a utilization review appeal if the service you request is available from a Participating Provider, even if the non-participating Provider has more experience in diagnosing or treating your condition. (Such an appeal will be treated as a grievance.) For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:

- A written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that we approved to treat your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, you also have the right to appeal the denial of a request for an authorization to a Non-Participating Provider when we determine that we have a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a utilization review appeal of an out-of-network authorization denial, you or your designee must submit a written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition:

- That the Participating Provider recommended by us does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
- Recommending a non-participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

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

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

3. Expedited Appeal. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of seventy-two (72) hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

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

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

4. Substance Use Appeal. Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, if we deny a request for inpatient substance use disorder treatment that was submitted at least twenty-four (24) hours prior to discharge from an inpatient admission, and you or your Provider file an expedited internal appeal of our adverse determination, we will decide the appeal within twenty-four (24) hours of receipt of the appeal request. If you or your Provider file the expedited internal appeal and an expedited external appeal within twenty-four (24) hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

I. Appeal Assistance.

If you need assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY 10010

Or call toll free: **1-888-614-5400**, or e-mail **cha@cssny.org**

www.communityhealthadvocates.org

4. External Appeal.

A. Your Right to an External Appeal.

In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases) ; or is an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

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

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

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

If we have denied coverage on the basis that the service is not Medically Necessary, you may appeal to an eternal appeal agent if you meet the requirements for an external appeal in paragraph "A" above.

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

If we have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two (2) requirements for an external appeal in paragraph "A" above and your attending physician must certify that your condition or disease is one for which:

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

In addition, your attending physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which you are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease,

and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

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

Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, if we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you meet the two (2) requirements for an external appeal in paragraph "A" above, and you have requested Preauthorization for the out-of-network treatment.

In addition, your attending physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending physician must be a licensed, board certified or board eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

E. Your Right to Appeal an Out-of-Network Authorization Denial.

Effective on the date of issuance or renewal of your Certificate on or after April 1, 2015, if we have denied coverage of a request for an authorization to a non-participating Provider because we determine we have a Participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service, you may appeal to an external appeal agent if you meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, your attending physician must: certify that the Participating Provider recommended by us does not have the appropriate training and experience to meet your particular health care needs; and recommend a non-participating Provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

For purposes of this section, your attending physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat you for the health service.

F. The External Appeal Process.

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

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

You can submit additional documentation with your external appeal request. If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three (3) business days to amend or confirm our decision. Please note that in the case of an expedited external appeal (described below), we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If Your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and us by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both you and us. The external appeal agent's decision is admissible in any court proceeding.

We will charge you a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

G. Your Responsibilities.

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

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. GHI has no authority to extend this deadline.

5. Electronic Filing of Claims. You have the option to submit a claim to us electronically by visiting our website. Or, you can submit a claim to us on paper according to instructions set forth in your Certificate.

6. Other Terms.

All other terms, conditions, exclusions and limitations of your Certificate of Insurance apply, except as specifically amended or updated by this rider.

GROUP HEALTH INCORPORATED ("GHI")

An EmblemHealth Company

55 Water Street

New York, New York 10041

RIDER ADDING COVERAGE FOR AUTISM SPECTRUM DISORDER

GROUP HEALTH INCORPORATED

This rider amends your [GHI][EmblemHealth]Certificate of Insurance. It adds coverage for the services described below in connection with the screening, diagnosis and treatment of autism spectrum disorder.

1. Autism Spectrum Disorder. GHI will cover the screening, diagnosis and treatment of autism spectrum disorder. Autism spectrum disorder refers to any pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS). Diagnosis refers to assessments, evaluations, or tests to diagnose whether a person has autism spectrum disorder. Treatment refers to the types of care listed below, as well as assistive communication devices prescribed and ordered for a person diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:

a. Behavioral health treatment. This refers to counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided and supervised by a behavior analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of the person. Applied behavior analysis is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. Providers who render behavioral health treatment under the supervision of a certified behavior analyst must meet standards of professionalism, supervision and relevant experience pursuant to regulations issued by New York State or, if services are rendered outside of New York State, comparable standards.

b. Psychiatric care. This refers to direct or consultative services provided by a psychiatrist licensed in the state where the psychiatrist practices.

c. Psychological care. This refers to direct or consultative services provided by a psychologist licensed in the state where the psychologist practices

d. Medical care provided by a licensed health care provider.

e. If this Policy otherwise covers therapeutic care, therapeutic care including therapeutic care which is deemed habilitative or non-restorative. Therapeutic care refers to services provided by a licensed or certified speech therapist, occupational therapist, social worker, or physical therapist.

f. If this Policy otherwise covers prescription drugs, pharmacy care. Pharmacy care refers to medications prescribed by a licensed health care provider legally authorized to prescribe.

Coverage for the services and items described above is generally subject to the same cost-sharing terms that normally apply to these services and items under your Policy when the services are received in connection with other conditions, illnesses and/or injuries. Cost-sharing means the co-pay charge(s) or deductible(s) and coinsurance terms that apply to your coverage. Home visits are subject to the same cost-sharing that applies to office visits. Assistive communication devices are subject to the cost-sharing terms that apply to specialist office visits.

Applied behavior analysis is not covered under your Policy in connection with conditions other than autism spectrum disorder. To the extent permitted by law, applied behavior analysis is also subject to a maximum benefit of six hundred and eighty (680) hours per person per year. This maximum benefit amount will periodically increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index (CPI).

GHI will cover assistive communication devices, including communication boards and speech generating devices, other dedicated devices (i.e. devices that generally are not useful to a person in the absence of a communication impairment), and computer software and/or applications that enable a non-dedicated device to function as a speech-generating device when medically necessary in connection with autism spectrum disorder. GHI will not cover computers, laptops, tablets and other non-dedicated devices. GHI will cover the replacement, repair and/or maintenance of assistive communication devices when not provided for under a manufacturer's warranty or purchase agreement and functionally necessary.

GHI will not cover services provided under an individualized education plan (IEP) through school districts pursuant to Article 89 of the New York State Education Law or similar programs administered in other states. However, services provided under the programs set forth below will not affect GHI's coverage of services rendered on a supplemental basis outside of an educational setting if the services are prescribed by a licensed physician or licensed psychologist:

- Early Intervention Services (EIS) individualized family services plan (IFSP) pursuant to New York State Public Health Law Section 2545;
- Individualized education plan (IEP) pursuant to Article 89 of the New York State Education Law;
- Individualized service plan (ISP) pursuant to regulations of the New York State Office for Persons with Developmental Disabilities (OPWDD).

Coverage for the screening, diagnosis and treatment of autism spectrum disorder is subject to utilization review and external appeals pursuant to applicable law, as well as case management and other managed care provisions. Coverage of assistive communication devices is also subject to same prior authorization requirements that apply to durable medical equipment (DME), if covered, under your Policy.

2. Other Terms. All other terms, conditions, limitations and exclusions found in your Certificate of Insurance remain in full force and effect except as specifically amended by this rider.

GROUP HEALTH INCORPORATED ("GHI")

An EmblemHealth Company

55 Water Street

New York, New York 10041

NEW YORK STATE CONTINUATION OF COVERAGE AND YOUNG ADULT OPTION COVERAGE

GROUP HEALTH INCORPORATED

This rider amends your GHI Certificate of Insurance as set forth below.

1. This rider changes the section of your Certificate entitled "Continuation of Coverage". It deletes the terms contained in the paragraph(s) entitled "Continuation of Coverage under New York State Law" and replaces them with the new terms set forth below.

Continuation of Coverage under New York State Law. There are cases where you may lose eligibility for coverage under this Policy, but not be eligible to continue coverage under Federal law. If the loss of eligibility is due to termination of employment or loss of membership in the class(es) eligible for coverage, you may be entitled to continue coverage under New York State law. Continued coverage is available without evidence of insurability. If continuation is available to the Group member under Federal law (COBRA), then the New York State continuation law does not apply. However, if you are eligible for less than thirty-six months (36) months of continuation benefits under Federal law, you may continue coverage under New York State law for up to thirty-six (36) months from the date your continuation of coverage under Federal law began.

The terms set forth below apply to New York State continuation of coverage.

(a) Continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. It is also not available if you become covered or could be covered by another group policy that provides similar benefits, unless that policy contains a pre-existing condition limitation.

(b) You must make a request to continue coverage in writing and submit your first premium payment within sixty (60) days of the later of the dates set forth below.

  (i) The date your coverage under this plan would otherwise terminate.

  (ii) The date notice of your right to continue coverage is issued to you.

(c) You must pay your group one hundred and two percent (102%) of the group rate to continue coverage.

(d) Your continuation of coverage will terminate on the first of the dates set forth below.

  (i) You become eligible for Medicare.

  (ii) You become covered under another group health care plan as an employee or dependent, unless that plan contains a pre-existing condition limitation.

  (iii) Thirty-six (36) months, if the qualifying event is termination of employment or membership in the class or classes eligible for coverage.

  (iv) Thirty-six (36) months if you are an eligible dependent who will otherwise lose coverage due to the death of the Group Member, divorce, legal separation, change in dependent status or the Group Member becoming eligible for Medicare. The thirty-six (36) months will be measured from the date coverage would otherwise be lost.

  (v) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

  (vi) The date that your group terminates coverage with GHI. However, if the group coverage is replaced by the group contract holder with similar coverage, you have the right to become covered under the other coverage for the balance of the period that you would have remained covered hereunder. The replacement plan must provide at least the same level of benefits provided by the prior group plan, reduced by any benefits payable under that plan. The prior group plan must provide benefits to the extent of its accrued liabilities and extension of benefits.

When your New York State continuation of coverage terminates, you may purchase a direct payment conversion contract from GHI. (See the section of your Certificate of Insurance entitled "Direct Payment Conversion.")

2. This rider changes the section of your Certificate entitled "Continuation of Coverage". It adds the new terms set forth below to the end of that section. This rider adds the following terms to your Certificate of Insurance.

New York State Young Adult Option. If your group provides coverage for dependents under this Policy and has not elected to cover unmarried children through age twenty-nine (29), you have the option to continue coverage of an eligible child under this Policy through age twenty-nine (29) at your own cost and without evidence of insurability while you remain covered under the Group Contract.

To be eligible to continue coverage under this young adult option, your child must be:

- Age twenty-nine (29) or younger;
- Unmarried;
- Not eligible for coverage under any employee health benefit plan, whether insured or self-insured, as an employee or member (except as a COBRA or state continuation of coverage beneficiary);
- Not covered under Medicare; and
- Living, working or residing in New York State or our service area.

The young adult option coverage will be the same coverage that is provided to the parent. You or the young adult must pay the premium rate that applies to individual only coverage under the Group Contract for this coverage. The young adult will be subject to his or her own separate co-pays, deductibles, coinsurance, coinsurance maximum and dollar and benefit maximums, as applicable, and the coverage will be subject to all of the terms and conditions of the Group Contract, including, but not limited to, any pre-existing condition limitation. If the parent's coverage changes, the young adult option coverage will also change in the same manner. A young adult's children are not eligible for coverage under this option.

You or the eligible young adult may request this continuation of coverage from your group in writing at the times set forth below:

- Within sixty (60) days following the date that the dependent would otherwise lose coverage based on reaching the dependent limiting age that applies to this Policy. In such a case, the coverage will be effective on the date that the coverage would have otherwise terminated.
- Within sixty (60) days after meeting the eligibility requirements for this coverage if the dependent's coverage previously terminated. In such a case, coverage will be prospective no later than thirty (30) days after the request and payment of the first premium.
- During the annual thirty (30) day open enrollment period that applies to your plan. In such a case, coverage will be prospective no later than thirty (30) days after the request and payment of the first premium.
- During the twelve (12) month period following the first renewal, issue or amendment date of the Group Contract on or after September 1, 2009, you or the child may elect prospective coverage through age twenty-nine (29) for a child whose coverage terminated under the terms of the Group Contract prior to that renewal, issue or amendment date. In such a case, coverage will be prospective no later than thirty (30) days after the request and payment of the first premium.

Your written request for this continuation of coverage together with the first premium payment must be given to your group within the time periods described above. Check with your group about how to request and pay for this continuation of coverage. You should pay the required premiums to your group, but not more often than on a monthly basis in advance, by the due date. A thirty (30) day grace period applies to these premium payments.

GHI will give you written notice of the right to continue coverage under the young adult option and the time period in which you must request it at least sixty (60) days before a dependent reaches the normal limiting age when coverage would otherwise terminate.

Young adult option coverage will terminate under this Policy on the earliest of the times set forth below.

- the date the young adult voluntarily terminates the coverage according to the terms of the contract;
- the date the young adult no longer meets the eligibility requirements;
- the end of the period for which premium was paid, if there is a failure to pay premium within the thirty (30) day grace period;
- the date the young adult's parent is no longer covered under the Group Contract (including as a COBRA or state continuation of coverage beneficiary);

- the date the Group Contract is terminated. (Note that if the group coverage is replaced by another group policy, then the young adult may be eligible to continue coverage under that new policy.)

3. Except as specifically provided otherwise in this rider, all other terms, conditions, limitations and exclusions of your Certificate of Insurance apply.

GROUP HEALTH INCORPORATED ("GHI")

An EmblemHealth Company

55 Water Street

New York, New York 10041

PATIENT PROTECTION AND AFFORDABLE CARE ACT GRANDFATHERED PLAN RIDER

GROUP HEALTH INCORPORATED

This Rider changes provisions in, or adds provisions to, your Certificate of Insurance, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively "Policy) issued by Group Health Incorporated as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Rider, the provisions herein apply to all persons covered under the Policy ("Members"). All of the terms, conditions, and limitations of the Policy to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider. This Rider shall take effect on your Policy renewal date on or after September 23, 2010.

1. **Grandfathered Plan**. We believe this Policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

   Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Customer Service by calling **(212) 501-4444** or visiting our Web site at **www.emblemhealth.com**. You may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**. Your group must notify us if the group or the plan sponsor changes the premium contribution rate that applies to your coverage under this Policy at any point during the plan year.
2. **Annual Limits**. Any annual dollar limit under the Policy that applies to Essential Benefits, whether such annual limit applies only to a covered Essential Benefit or includes covered Essential Benefits and other covered services, is hereby deleted. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act. Not all Essential Benefits may be covered under your Contract and/or Certificate. Only the Essential Benefits listed as covered services in your Contract or Certificate are covered. Note that annual dollar limits may remain in effect for specific covered services other than Essential Benefits. Also, if you have prescription drug coverage and you have a separate annual dollar limit on certain covered items that are not prescription drugs, such as enteral formulas and modified solid food products, that annual dollar limit will continue to apply.
3. **Pre-Existing Conditions**. Under this Rider, the provision, if any, in the Policy that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Policy for a stated period is hereby deleted in its entirety with respect to all Members under the age of 19.
4. **Lifetime Dollar Limits Deleted**. Any lifetime dollar limit under the Policy that applies to Essential Benefits, whether such lifetime limit applies only to an Essential Benefit or includes covered Essential Benefits and other covered services, is hereby deleted in its entirety. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act. Not all Essential Benefits may be covered under your Certificate. Only the Essential Benefits listed as covered services in your Certificate are covered. Note that lifetime dollar limits for specific covered services other than Essential Benefits remain in effect.
5. **Dependent Children Covered to Age 26**. If the Policy makes coverage of dependents available, this Rider applies to coverage of children as follows:

   A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under the Policy. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Rider. If your children are eligible for employer-sponsored coverage on their own, then they are not eligible for dependent coverage to age 26. Coverage for these children ceases on the date otherwise specified under the Policy.

Coverage for Your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while your coverage remains in effect and the child remains in such condition, if You submit proof of Your child's incapacity within 31 days of Your child's attaining age 26. You must periodically submit proof of your child's continued incapacity upon our request.

B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.

D. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

E. The provisions of any Rider to the Policy that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 5 that apply to children under the age of 26.

6. **Rescission**. We may rescind your coverage if you or your group commit fraud or make an intentional misrepresentation of material fact. We will give you 30 days notice before we rescind your coverage.

7. **Other Provisions**. All of the terms, conditions, and limitations of the Policy to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER
AMENDING COVERAGE FOR DENTAL/DENTAL-RELATED BENEFITS

GROUP HEALTH INCORPORATED

This rider amends your Contract or Certificate. It amends the section that is entitled "Covered Medical Services." It amends the paragraph entitled "Dental/Dental Related Benefits". It adds the following new subparagraph:

"(g) Dental care or treatment necessary due to congenital disease or anomaly."

All other terms and conditions of your Contract or Certificate apply.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER FOR
CITY OF NEW YORK EMPLOYEES AND RETIREES

GROUP HEALTH INCORPORATED

Group Insurance Certificate Rider to Be Attached To Group Insurance Certificate Issued under Group Policy PLC-1032E by Group Health Incorporated To:

CITY OF NEW YORK EMPLOYEES AND RETIREES
(Herein called the Employer)

Group Health Incorporated certifies that as of the later of (a) July 1, 1998, or (b) the effective date of your certificate, your insurance under the above-mentioned Group Policy is modified as follows:

1. By substituting the following for subparagraph "(e)" which appears in paragraph "1. General Medical Care," in **SECTION FIVE: Covered Medical Services** of the certificate.

"(e) Chiropractic Care."

2. By adding a new 2nd paragraph to paragraph "3. Surgery," in **SECTION FIVE: Covered Medical Services** of the certificate.

"You are covered for surgery to reconstruct a breast. The surgery must follow a mastectomy. You are covered for all stages of reconstruction of the breast on which the mastectomy has been performed. You are also covered for surgery and reconstruction of the other breast. This surgery must be to produce a symmetrical appearance. You are also covered for reconstructive surgery. Such surgery must be incidental to or follow surgery resulting from trauma, infection or other disease of the part of the body involved. You are also covered for reconstructive surgery performed due to congenital disease or anomaly of a covered child which has resulted in a functional defect."

3. By adding the following paragraph No. "26. Second Medical Opinion for Cancer Diagnosis and Treatment," to **SECTION FIVE: Covered Medical Services** of the certificate.

"Second Medical Opinion for Cancer Diagnosis and Treatment. You are covered for a second medical opinion in any of the events set forth below.

- A positive diagnosis of cancer.
- A negative diagnosis of cancer.
- A recurrence of cancer.
- A recommendation of a course of treatment for cancer.

If your physician gives you a written referral to a specialist for the second opinion, then you are covered for that opinion. You only need a written referral when the second opinion is going to be from a non-participating specialist. Coverage will be subject to the Co-pay Charge that applies to a specialist consultation rendered by a Participating Provider. This applies even if the referral is made to a non-participating Provider. If you have written referral, then you must submit it to GHI with your claim form.

If you do not have a written referral, then you are also covered for the second opinion. Coverage will be subject to the terms that apply to covered medical services rendered by non-participating providers. You must pay the provider directly. You are responsible to pay any difference between GHI's payment and the provider's charge.

In order to be covered, the second opinion must be rendered by an appropriate specialist."

4. By substituting the following for subparagraph "(a)" which appears in paragraph "3. GHI Prescription Drug Coverage," in **SECTION FOURTEEN: Medicare Eligible Coverage** of the certificate.

"(a) Covered Items. You are covered for drugs which by law require a written prescription. The drugs must be dispensed by a licensed pharmacist. A Provider must have written the prescription. That Provider must be legally authorized to write the prescription. Payment will be made only when the drug is prescribed for your use. Insulin is covered whether or not it is dispensed by a written prescription.

In addition to covered prescription drugs, you are covered for enteral formulas if each of the criteria set forth below are met.

- A covered Provider has given a written order and/or a prescription.
- It must be proven effective as a disease-specific treatment regimen for persons who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic disability, mental retardation or death.

You are also covered for modified solid food products that are low in protein or contain modified protein if each of the criteria set forth below are met.

- An authorized Provider has given a written order and/or a prescription.
- It must be for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

You are covered for these modified food products up to a maximum of $2,500 per calendar year or any continuous twelve (12) month period. You must submit your written order or prescription and store receipt for modified food products along with a completed claim form to: GHI, P.O. Box 2868, New York, New York 10116-2868."

5. By substituting "30 visits" for "$900" and "60 visits" for "$1,800" where they appear in subparagraph "1. Outpatient Mental Health Benefits" in **SECTION FIFTEEN: Catastrophic Coverage** of the certificate.

6. By adding the following paragraph No. "11. Subrogation and Reimbursement," to **SECTION THIRTEEN: Miscellaneous Provisions** of the certificate.

"Subrogation and Reimbursement. This paragraph applies when another party (including any insurance carrier) is, or is alleged to be, liable for your injury, illness or other condition and GHI has provided benefits in connection with that injury, sickness or condition. GHI is subrogated to all of your rights against any such party (including any insurance carrier) to the extent of the reasonable value of the benefits provided to you under this plan. This means that GHI has the right independently of you, or as a plaintiff-intervenor in any action you may have commenced, to proceed against the party responsible for your injury, illness or condition to recover the benefits that have been provided under the GHI plan. You must provide reasonable cooperation with GHI in proceeding against the party responsible for your injury, illness or condition to recover the benefits GHI has provided. In addition, in GHI's sole discretion, if you (or your legal representative, estate or heirs) make a recovery from any liable party (including any insurance carrier), you will promptly reimburse GHI for any benefits provided by GHI in connection with the injury, illness or condition from any settlement, verdict or insurance proceeds received to the extent that such settlement, verdict or other amounts received is specifically identified as being for medical expenses paid out.

7. By substituting the following for subparagraph "(i)" of paragraph "(c) Prescription Drugs." which appears in the last section of the certificate entitled "**Optional Rider for Active Employees and Non-Medicare Eligible Retirees**."

"(i) Covered Items. You are covered for drugs which by law require a written prescription. The drugs must be dispensed by a licensed pharmacist. A Provider must have written the prescription. That Provider must be legally authorized to write the prescription. Payment will be made only when the drug is prescribed for your use. Insulin is covered whether or not it is dispensed by a written prescription.

In addition to covered prescription drugs, you are covered for enteral formulas if each of the criteria set forth below are met.

- A covered Provider has given a written order and/or a prescription.
- It must be proven effective as a disease-specific treatment regimen for persons who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic disability, mental retardation or death.

You are also covered for modified solid food products that are low in protein or contain modified protein if each of the criteria set forth below are met.

- An authorized Provider has given a written order and/or a prescription.
- It must be for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

You are covered for these modified food products up to a maximum of $2,500 per calendar year or any continuous twelve (12) month period. You must submit your written order or prescription and store receipt for modified food products along with a completed claim form to: GHI, P.O. Box 2868, New York, New York 10116-2868."

APPLICABILITY OF OTHER PROVISIONS

The Group Policy provides that all of its provisions and conditions not inconsistent with the provisions and conditions referred to in this Rider shall apply to this insurance.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER ADDING COVERAGE FOR PROSTATE CANCER SCREENING

GROUP HEALTH INCORPORATED

This rider amends your GHI Contract or Certificate as set forth below.

COVERED MEDICAL SERVICES.

This rider amends the section of your Contract or Certificate that is entitled as "Covered Medical Services." It adds coverage for Prostate Cancer Screening by adding the following new provision:

Prostate Cancer Screening. GHI will cover prostate cancer screening as set forth below.

- At Any Age- Coverage will be provided for standard diagnostic testing including, but not limited to, coverage for:
  i) Digital Rectal Examination; and
  ii) Prostate-Specific Antigen Test for men at any age who have a prior history of prostate cancer.
- Age Fifty (50) and Older- Coverage will be provided for an annual standard diagnostic examination including, but not limited to, coverage for:
  i) Digital Rectal Examination; and
  ii) Prostate-Specific Antigen Test for men age fifty (50) and older who are asymptomatic of prostate cancer.
- Age Forty (40) and Older- Coverage will be provided for an annual standard diagnostic examination including, but not limited to, coverage for:
  i) Digital Rectal Examination; and
  ii) Prostate-Specific Antigen Test for men age forty (40) and older with a family history of prostate cancer or other prostate cancer risk factors.

All other terms, conditions, limitations and exclusions found in your Contract or Certificate remain in full force and effect except as amended by this rider.

GROUP HEALTH INCORPORATED

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INFERTILITY SERVICES RIDER

GROUP HEALTH INCORPORATED

1. This rider amends your GHI Contract or Certificate. It adds the new terms set forth below to the sections of your Contract or Certificate entitled "Covered Inpatient Services", "Covered Outpatient Services" and/or "Covered Medical Services."

"**Infertility Services**. GHI will cover the diagnosis and treatment of correctable medical conditions that result in infertility. Infertility refers to the inability to conceive after one (1) year of unprotected intercourse. A physician must prescribe the diagnosis and treatment as part of his/her overall plan of care. The diagnosis and treatment must also be consistent with the guidelines for infertility coverage set forth by the New York State Department of Insurance.

GHI will cover the types of services set forth below.

- Surgical or medical procedures that correct malformation, disease or dysfunction resulting in infertility.
- Diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug regimens, including:

  Hysterosalpingogram.
  Hysteroscopy.
  Endometrial biopsy.
  Laparoscopy.
  Sono-hysterogram.
  Post coital tests.
  Testis biopsy.
  Semen analysis.
  Blood tests.
  Ultrasound.

GHI will **NOT** cover the items or services set forth below. GHI also will not cover any items or services provided to you in connection with the items or services set forth below.

- Prescription drugs for use in the diagnosis and treatment of infertility as set forth above. (However, if you have prescription drug insurance through GHI, then GHI will cover prescription drugs for use in the diagnosis and treatment of infertility according to the terms that apply to your GHI prescription drug insurance.)
- In vitro fertilization (IVF).
- Gamete intrafallopian tube transfers.
- Zygote intrafallopian tube transfers.
- Reversal of elective sterilization.
- Sex change procedures.
- Cloning.
- Medical or surgical services or procedures that are deemed experimental pursuant to guidelines for infertility coverage set forth by the New York State Department of Insurance."

2. All other terms, conditions, limitations, and exclusions of your GHI Contract or Certificate remain in full force and effect except as modified by this rider.

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441 Ninth Avenue, New York NY 10001

RIDER TO AMEND
MAMMOGRAPHY SCREENING COVERAGE

GROUP HEALTH INCORPORATED

1. This rider amends your GHI Contract or Certificate. It amends your mammography screening coverage. It reduces the age at which you become eligible for benefits for an annual mammography screening from fifty (50) years of age to forty (40) years of age. If you are forty (40) years of age or older, GHI will cover a mammography screening every year. However, GHI will cover mammography screening more frequently if your physician recommends it.

2. All other terms, conditions, limitations, and exclusions of your GHI Contract or Certificate remain in full force and effect except as modified by this rider

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OSTEOPOROSIS SCREENING RIDER

GROUP HEALTH INCORPORATED

1. This rider amends your GHI Contract or Certificate. It adds the new paragraph set forth below to the section entitled 'Medical Services' or 'Medical Care.'

"Osteoporosis Screening. GHI will cover bone mineral density measurements or tests, including but not limited to dual-energy x-ray absorptiometry, in accordance with standards that include the criteria established by Medicare and the national institutes of health (NIH) for the detection of osteoporosis. In order to qualify for benefits, you must meet the criteria of Medicare or NIH, and to the extent consistent with such criteria, meet one or more of the conditions set forth below.

- You must be previously diagnosed as having osteoporosis or having a family history of osteoporosis.
- You must have symptoms or conditions indicative of the presence, or the significant risk of osteoporosis.
- You must be on a prescribed drug regiment posing a significant risk of osteoporosis.
- You must have lifestyle factors to such a degree as posing a significant risk of osteoporosis.
- You must have age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.

GHI will **NOT** cover bone mineral density prescription drugs, drugs and devices. However, if you have prescription drug insurance through GHI, then GHI will cover bone mineral density prescription drugs and devices approved by the federal food and drug administration (FDA) or generic equivalents as approved substitutes, subject to the terms that apply to your GHI prescription drug insurance. "

2. All other terms, conditions, limitations, and exclusions of your GHI Contract or Certificate remain in full force and effect except as modified by this rider.

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441 Ninth Avenue, New York NY 10001

RIDER
TO AMEND COVERAGE FOR
CONTRACEPTIVE DRUGS & DEVICES

GROUP HEALTH INCORPORATED

1. General. This rider amends your GHI prescription drug benefits. It deletes any and all terms in your GHI prescription drug rider(s) and/or in the prescription drug section of your GHI Contract or Certificate of Insurance that address contraceptive drugs and devices. You are covered for contraceptive drugs and devices according to the terms of this rider.

2. Covered Contraceptive Drugs & Devices. GHI will cover contraceptive drugs or devices approved by the federal food and drug administration ("FDA") or generic equivalents approved as substitutes by the FDA. The contraceptive drug or device must be prescribed for you by a provider that is legally authorized to prescribe pursuant to applicable law.

3. Benefits. GHI will provide benefits for contraceptive drugs and devices according to the same terms and conditions that apply to other prescription drugs as set forth in your GHI prescription drug rider(s) and/or the prescription drug section of your GHI Contract or Certificate of Insurance. For example, benefits for contraceptive drugs and devices are subject to the same cost-sharing terms (i.e. deductible(s), coinsurance and Co-Pay Charge(s)) and other terms that apply to your benefits for other prescription drugs. They are also subject to the same annual and lifetime maximums that apply to your benefits for other prescription drugs.

Also, if your GHI prescription drug benefits cover only prescription drugs dispensed by a GHI participating pharmacy, then GHI will only cover contraceptive drugs and devices when they are dispensed by a GHI participating pharmacy. Similarly, if your GHI prescription drug benefits include a mail order program, you may use the mail program to obtain contraceptive drugs and devices subject to the same terms and conditions that apply to other prescription drugs that you obtain through the mail order program.

Contraceptive drugs and devices are also subject to the same program requirements as other prescription drugs as set forth in your GHI prescription drug rider(s) and/or the prescription drug section of your GHI Contract or Certificate of Insurance. For example, any terms of your prescription drug coverage that require you to use generic drugs in certain circumstances or use the mail order program apply to contraceptive drugs and devices as well.

Please consult your GHI prescription drug rider and/or the prescription drug section of your GHI Contract or Certificate of Insurance for the details applicable to your prescription drug and contraceptive drug and device benefits.

Certain contraceptive drugs and devices require an office visit, such as drugs or devices that require injection or insertion. If you receive such a drug or device from a GHI Participating Provider during an office visit, GHI will cover the drug or device in full. If you receive it from a non-participating Provider during an office visit, you must file a claim with GHI and GHI will reimburse you directly at the applicable in-network allowance for the drug or device. Note, however, that if your GHI program only covers services rendered by Participating Providers, then you must receive the drug or device during an office visit to a Participating Provider. GHI will not cover the drug or device if it is dispensed during an office visit to a non-participating Provider.

4. Other Terms. All other terms, conditions, limitations, and exclusions of your GHI Contract, Certificate of Insurance and/or prescription drug rider(s) remain in full force and effect except as modified by this rider.

GROUP HEALTH INCORPORATED

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RIDER TO AMEND PRESCRIPTION DRUG COVERAGE

RETAIL DRUG PROGRAM

Deductible:	$150.00 per person per calendar year, $450.00 per family per calendar year.
Generic Drugs:	After the deductible(s), you pay a $5.00 Co-pay Charge per prescription or 20% Coinsurance per prescription, whichever is greater. If the total cost of the prescription is less than $5.00, then you must pay the full cost of the prescription.
Brand Name Preferred Formulary Drugs:	After the deductible(s), you pay a $25.00 Co-pay Charge per prescription or 40% Coinsurance per prescription, whichever is greater. If the total cost of the prescription is less than $25.00, then you must pay the full cost of the prescription.
Brand Name Non-Formulary Drugs:	After the deductible(s), you pay a $40.00 Co-pay Charge per prescription or 50% Coinsurance per prescription, whichever is greater. If the total cost of the prescription is less than $40.00, then you must pay the full cost of the prescription.
Retail Drug Program Annual Maximum:	Unlimited

MAINTENANCE DRUG PROGRAM

Generic Drugs:	You pay a $10 Co-pay Charge per prescription.
Brand Name Preferred Formulary Drugs:	You pay a $40 Co-pay Charge per prescription.
Brand Name Non-Formulary Drugs:	You pay a $60 Co-pay Charge per prescription.
Maintenance Drug Program Annual Maximum:	Unlimited.

GROUP HEALTH INCORPORATED

This prescription drug rider amends your GHI Certificate of Insurance. It changes your coverage for prescription drugs. It deletes the prescription drug coverage terms in your Certificate and it replaces them with the new terms set forth below.

PRESCRIPTION DRUG COVERAGE

1. Retail Prescription Drug Coverage.

GHI uses a prescription benefits manager ("PBM") in order to administer its prescription drug benefit program. GHI will provide prescription drug benefits as set forth in this rider. Under the retail program, you may obtain prescription drugs from GHI participating pharmacies or from non-participating pharmacies. Note that you will save time and minimize your out of pocket expenses by using GHI participating pharmacies.

The retail program covers "acute" prescription drugs. An acute prescription drug is a prescription that is medically necessary for purposes of short-term treatment for a condition that is not chronic in nature. The quantity of an acute prescription drug dispensed cannot exceed a thirty (30) consecutive day supply.

If you require a maintenance drug, you may obtain only the initial prescription and one (1) refill for a maintenance drug at a retail pharmacy. You must obtain all subsequent refills for the maintenance drug through the PBM's home delivery program. See Section 2.

You are subject to the retail prescription drug deductible(s) shown at the front of this rider. After you have met the deductible(s), you are subject to the prescription Co-pay Charge or Coinsurance set forth on the front of this rider. These costs may vary depending upon whether you receive a drug that is part of the formulary that applies to this program. The formulary is a list of prescription drugs that are preferred for use. The formulary is subject to periodic review and modification by GHI. You will receive the preferred formulary pocket guide with your prescription drug I.D. Card. This program has an "open" formulary. This means that you are covered for preferred formulary drugs as well as non-formulary prescription drugs. The Co-pay Charge or Coinsurance may also vary depending upon whether you receive a generic drug or a brand name drug. A generic drug is a prescription drug that is marketed under its non-proprietary name after the patent of a brand name drug expires. A brand name drug refers to the proprietary name of a prescription drug before or after its patent has expired.

If you receive a formulary or non-formulary brand name drug that has a generic equivalent, you are responsible to pay the difference between the cost of the brand name drug and the generic drug, as well as the Co-pay Charge or Coinsurance that applies to the generic drug.

Insulin, glucagon, syringes and oral agents used for controlling blood sugar and other covered items listed from time to time by the Commissioner of the New York State Department of Health to be medically necessary for the treatment diabetes are not subject to the deductible or annual maximum listed on the front of this rider. These items are always subject to a five-dollar ($5) Co-pay Charge when prescribed for the purpose of diabetes management.

If you use a GHI Participating Pharmacy, you must present your GHI I.D. Card at the time of your purchase.

The pharmacist will fill your prescription and bill you for the applicable deductible(s) and/or Co-pay or Coinsurance at the point of sale.

If you use a non-participating pharmacy, you must pay the full cost of your prescription at the point of sale and then file a claim form with GHI to request benefits. After you meet the deductible(s), GHI will reimburse you for covered prescriptions at the amount that GHI would have paid to a GHI participating pharmacy for the prescription, less the applicable Co-pay Charge or Coinsurance. You are responsible to pay any difference between GHI's payment and the cost of your prescription. To obtain information about where to submit claims and to obtain a claim form, please call the PBM's Customer Service at: [Insert telephone number].

2. Maintenance Drug Program.

Your benefits also include coverage under a Maintenance Drug Program. This program is available only through the GHI PBM.

The GHI Maintenance Drug Program dispenses long-term maintenance prescriptions by mail. A maintenance prescription drug is a prescription that is required on an on-going basis in connection with the treatment of a chronic condition. You may obtain only the initial prescription and one (1) refill for a maintenance drug at a GHI participating pharmacy. You must obtain all subsequent refills for the maintenance drug through the home delivery program.

Under the home delivery program, you may receive a prescription drug supply of up to sixty (60) consecutive days. The program saves you time. It may also save you money by reducing the amount of the Coinsurance you must pay for a sixty (60) day supply of a maintenance drug. When you become covered, you will receive information about how to obtain a maintenance drug under this program.

You are subject to the prescription Co-pay Charge set forth at the front of this rider. The Co-pay Charge may vary depending upon whether you receive a generic drug or a brand name drug and a formulary or non-formulary drug. The formulary is a list of prescription drugs that are preferred for use. The formulary is subject to periodic review and modification. You will receive the preferred formulary pocket guide with your prescription drug I.D. Card. This program has an "open" formulary. This means that you are covered for preferred formulary drugs as well as non-formulary prescription drugs.

A generic drug is a prescription drug that is marketed under its non-proprietary name after the patent of a brand name drug expires. A brand name drug refers to the proprietary name of a prescription drug before or after its patent has expired.

Insulin, glucagon, syringes and oral agents used for controlling blood sugar and any other covered items listed from time to time by the Commissioner of the New York State Department of Health to be medically necessary for the treatment diabetes are not subject to the deductible or annual maximum listed on the front of this rider, if any. These items are subject to the lesser of the applicable Coinsurance or a five-dollar ($5) Co-pay Charge when prescribed for the purposes of diabetes management.

To take part in the Maintenance Drug Program, ask your doctor if a maintenance quantity is suitable for you. If so, have a doctor specify the maintenance quantity of the drug to be dispensed. Prescriptions should always be sent to the PBM. They should not be sent to GHI.

3. Covered Items.

You are covered for drugs that require a written prescription by law. A licensed pharmacist must dispense the drugs. A Provider must have written the prescription. That Provider must be legally authorized to write the prescription. Payment will be made only when the drug is prescribed for your use. Insulin is covered whether or not it is dispensed by a written prescription.

GHI will also provide coverage for enteral formulas if each of the conditions set forth below is met:

- A physician or other licensed health care provider legally authorized to prescribe under Title Eight of the New York State Education Law gave a written order or prescription for the formula;
- The formula is medically necessary; and
- The formula has been proven effective as a disease specific treatment regimen for persons who are or will become mal-nourished or suffer from disorders that, if left, untreated, cause chronic disability, mental retardation or death.

GHI will also cover modified solid food products that are low in protein or contain modified protein if each of the conditions set forth below is met.

- A physician or other licensed health care provider legally authorized to prescribe under Title Eight of the New York State Education Law gave a written order or prescription for the product;
- The written order or prescription must be medically necessary; and
- The product must be for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

You are covered for these modified solid food products up to a maximum of $2,500 per calendar year.

GHI will cover prescription drugs approved by the federal food and drug administration (FDA) or their generic equivalents

approved as substitutes by the FDA for use in the diagnosis and treatment of infertility. GHI will also cover bone mineral density prescription drugs and devices approved by the FDA or their generic equivalents approved as substitutes by the FDA.

Effective on July 1, 2005, GHI will also cover asthma and psychotropic prescription drugs under this rider.

4. Refills.

Unless your doctor's prescription or State or Federal laws state otherwise, you may have prescriptions refilled as needed.

5. Annual Maximum.

GHI will not pay more than the maximum amount(s) shown on the front of this rider in a calendar year for prescription drugs under this rider.

6. Clinical Prior Authorization Program.

This Program requires utilization review of certain classes of prescription drugs. These drug classes include osteo-arthritis/anti-inflammatory medications and gastrointestinal (GI) medications that block acid secretion.

If you use a GHI participating pharmacy, utilization review will occur at the point of sale. If your prescription is for a drug that is subject to the Program, your GHI participating pharmacist will inform you, and you must notify your physician. Your physician should then contact GHI's prescription benefits manager (PBM). The PBM will decide whether the prescription is medically necessary for your treatment or condition. The PBM will also decide whether the quantity or duration of the prescription is medically appropriate. The PBM will then inform you and your physician of its decision(s).

If the PBM approves the prescription, then the GHI participating pharmacist will fill your prescription and GHI will cover the prescription. If the PBM does not approve the prescription, then the PBM will notify you and your physician and pharmacist of its decision and GHI will not cover the prescription. If the PBM approves the prescription, but at a reduced quantity or duration, then the PBM will notify you and your physician of its decision and GHI will cover only the reduced quantity or duration of the drug.

If you use a non-participating pharmacy, utilization review will generally occur when GHI processes your prescription drug claim. The PBM will decide whether the prescription is medically necessary for your treatment or condition. The PBM will also decide whether the quantity or duration of the prescription is medically appropriate. The PBM will then inform you and/or your physician of its decision(s) and, if appropriate, GHI will pay benefits for your claim. If you would like to request prior authorization from the PBM before you fill your prescription, please ask the prescribing doctor to call the PBM at [1-800-417-8164] to initiate the prior authorization process. The PBM will inform you and your physician of its decision(s).

The PBM will make its utilization review decision(s) in the time periods and in accordance with the other requirements that apply to utilization review decisions as set forth in your Certificate. If you disagree with the PBM's decision(s), you may file an appeal. Please refer to your Certificate for information about how to file an appeal.

The prescription drug classes listed below require prior authorization. Examples of common drugs within each class are also listed below.

Osteo-Arthritis/Anti-Inflammatory Medications
celecoxib (Celebrex)
rofecoxib (Vioxx)
valdecoxib (Bextra)

GI Medications that Block Acid Secretion
lansoprazole (Prevacid)
omeprazole (Prilosec)
rabeprazole (Aciphex)

pantoprazole (Protonix)
esomeprazole (Nexium)

7. Items Not Covered.

You are not covered under this prescription drug rider for the items set forth below.

(a) Medication available as an over-the-counter (OTC) drug which does not require a prescription order or refill under Federal or State law, and any medication that is equivalent to an over-the-counter medication, except insulin.

(b) Prescription drugs that are not medically necessary.

(c) Single entity and combination products, which have questionable effectiveness under the FDA's Drug Efficacy Study Implementation ("DESI") program.

(d) Drugs dispensed while you are a bed patient in a hospital or other institution or while you are receiving covered home health care by or on behalf of a certified home health agency. Such drugs may be covered as part of your hospital, home care or other benefits.

(e) Contraceptive drugs and devices.

(f) Medications that have been prescribed for cosmetic purposes, unless otherwise medically necessary.

(g) Drugs related to a medical service, which is not covered under a member's Certificate of Insurance.

(h) Injectibles, psychotropics, asthma and chemotherapy prescription drugs dispensed by a pharmacy are not covered under this rider. These drugs are covered under the PICA program when dispensed by a pharmacy. However, commencing on July 1, 2005, asthma and psychotropic prescription drugs are covered under this rider.

Notwithstanding any of the provisions contained herein, GHI shall not provide coverage for any drug(s) that are either experimental or investigational in nature or which the FDA has not approved for your specific diagnosis or condition unless otherwise superseded by state or federal law or regulation or recommended pursuant to an external review.

8. Other Terms.

All other terms, conditions, limitations and exclusions found in your GHI Certificate of Insurance remain in full force and effect except as amended by this ride

GROUP HEALTH INCORPORATED

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441 Ninth Avenue, New York NY 10001

RIDER AMENDING PRESCRIPTION DRUG BENEFITS

GROUP HEALTH INCORPORATED

This rider amends your GHI Certificate of Insurance. The section of your Certificate, which addresses coverage for prescription drug benefits, is modified as follows:

Any and all references to a specific prescription drug benefits manager and any related addresses and/or phone numbers are deleted and replaced with the following:

Express Scripts, Inc.

767 Electronic Drive

Horsham, PA 19044

877-534-3682

All other terms and conditions of your Certificate remain in full force and effect.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER TO AMEND THE GHI COMPREHENSIVE BENEFITS PLAN (CBP) FOR CITY OF NEW YORK EMPLOYEES AND RETIREES

Effective April 1, 2004

GROUP HEALTH INCORPORATED

This rider amends your GHI Certificate of Insurance as set forth below.

A. This rider deletes Section Three and replaces it with the new Section Three set forth below.

"SECTION THREE. - USE OF PARTICIPATING PROVIDERS:

1. Participating Providers. GHI Participating Providers accept GHI's Schedule of Allowances or negotiated rate(s) as payment in full for covered services. There is no deductible or coinsurance when you use a Participating Provider. However, certain services are subject to a Co-pay Charge as set forth below.

A $15 Co-pay Charge applies to each home or office visit and out-of-hospital consultation, except as specifically provided otherwise below.

A $20 Co-pay Charge applies to each home or office visit and out-of-hospital consultation to a specialist. Specialists include surgeons, all surgical sub-specialties and dermatologists. Specialists include providers who practice: Cardiothoracic and thoracic surgery, colon and rectal surgery, general surgery, neurological surgery, ophthalmology, oral surgery, orthopaedic and hand surgery; otolaryngology, plastic surgery, podiatry and podiatric surgery, traumatic surgery, urology, vascular and veno surgery.

A $15 Co-pay Charge applies to diagnostic X-rays and laboratory tests. This Co-pay Charge will apply to each diagnostic X-ray and laboratory test performed by a Participating Provider. A maximum of one Co-pay Charge will apply per date of service, per provider. This means that if one Participating Provider performs two tests on the same day, you will be subject to one Co-pay Charge only. However, if two different Participating Providers perform one or more lab tests each on the same day, you will be subject to a maximum of two Co-pay Charges. A maximum of two diagnostic Co-pay Charges will apply per date of service. This maximum applies regardless of the number of Participating Providers you see on that date.

Special terms apply to coverage of private duty professional nursing services, durable medical equipment, home care services, home infusion therapy and assisted reproductive technology services. (See Section Five, Paragraphs 23, 24, 21, 22 and 27 respectively).

The use of Participating Providers controls your out-of-pocket expenses. Consult your Directory of Participating Physicians and other Providers or phone GHI to obtain the names of Participating Providers in your area.

You must advise the Participating Provider of your GHI/CBP coverage before the service is rendered. You must verify that the Provider is a Participating Provider. You should not pay the provider directly for any covered services except for the Co-pay Charge when applicable.

2. Benefits Available. Most, but not all services covered under this Certificate are available through Participating Providers."

B. This rider amends Section Four of the Certificate. It deletes paragraph 2 and replaces it with the new paragraph 2 set forth below.

"**2. Benefits**. When you use a non-participating Provider, benefits are paid under the City of New York Non-Participating Provider Schedule in accordance with the Allowed Charge for all services. (See Section Two, Paragraph 9). Except as otherwise specifically provided, these benefits are subject to the terms below:

(a) **Annual Deductible**. You are subject to an annual deductible of $200 per person up to a maximum deductible for a family of three or more of $500 in each calendar year. GHI will make payment to you after you have paid this amount. The amount credited to your deductible shall be based on the Allowed Charge.

(b) **Common Accident Provision**. More than one family member may be involved in an accident. If that occurs, only $175 in allowed expenses are required to satisfy the deductible for that accident, for all covered persons involved. The $175 is first applied towards the Subscriber's deductible. If the Subscriber was not involved, it is applied toward the oldest member of the family who was involved.

(c) **GHI Payments**. After you have met your deductible, GHI will pay 100% of the Allowed Charge for covered services.

(d) **Annual Maximum**. There is no annual dollar maximum for covered services rendered by non-participating Providers. However, each person is subject to a calendar year maximum of $100,000 for Private Duty Professional Nursing Services.

(e) **Lifetime Maximum.** Each person is subject to a lifetime maximum of $2,000,000 in covered expenses.

Special terms apply to coverage of excess hospitalization coverage/inpatient hospital charges, private duty professional nursing services, durable medical equipment, home care services, home infusion therapy and certain assisted reproductive technology services. (See Section Five, Paragraphs 14, 23, 24, 21, 22 and 27 respectively)."

C. This rider amends Section Five of the Certificate. It adds the new paragraph 27 set forth below.

"27. Assisted Reproductive Technology (ART) Services. You are covered for Assisted Reproductive Technology (ART) services as set forth in this paragraph.

a. Payments. If you receive a covered ART service(s) from a GHI Participating Provider, GHI will pay 75% of the Schedule or negotiated rate to the provider. You are responsible to pay 25% of the Schedule or negotiated rate to the Participating Provider. If you receive a covered ART service(s) from a non-participating Provider, GHI will reimburse you up to 75% of the Allowed Charge after you have met the annual deductible(s) that applies to covered medical services rendered by non-participating Providers. You are responsible to pay any difference between GHI's payment and the non-participating Provider's charge for the service(s).

b. **ART Services**. In addition to infertility treatment services listed elsewhere in this Certificate, you are covered for ART services associated with infertility. Infertility is defined as the inability to conceive after twelve (12) months of unprotected intercourse. Subsequent to the twelve (12) month period, if pregnancy has not been achieved after undergoing four (4) months of less invasive infertility treatment, and you have a normal hormone level (FSH), GHI will cover one (1) or more of the ART services set forth below. GHI will not cover more than three cycles of ART per person per lifetime.

- In Vitro Fertilization (IVF).
- Gamete Intrafallopian Transfer (GIFT).
- Zygote Intrafallopian Transfer (ZIFT).
- Laboratory tests and procedures in connection with IVF, ZIFT and GIFT above. GHI will cover such tests and procedures commencing at the point of oocyte retrieval for a female and testicular sperm extraction for a male.
- Preparation of a cryo-preserved embryo for transfer and cryo-preservation of embryos for the services listed in this paragraph.

If infertility cannot be documented, the patient must undergo six (6) months of less-invasive procedures prior to ART, including three (3) unstimulated intrauterine inseminations and three (3) stimulated intrauterine inseminations (i.e. a total of six (6) treatments). The patient must undergo at least three (3) of these treatments with fertility drugs. If you have undergone an elective sterilization procedure, such as an elective tubal ligation or vasectomy, you are not eligible for benefits unless:

- You undergo a reversal of the elective sterilization procedure and have not become pregnant after one (1) year of unprotected intercourse; or
- GHI determines that reversal of the elective sterilization procedure will not improve the likelihood of conception due to multifactorial causes of infertility.

c. **Pre-certification**. You must pre-certify all Assisted Reproductive Technology (ART) services listed in paragraph (a) of this paragraph with GHI prior to the beginning of each ART cycle. To pre-certify, please call GHI (212) 615-4662 in New York and Long Island and 1-800-223-9870 outside of New York and Long Island BEFORE SERVICES ARE RENDERED TO YOU. If you use a GHI Participating Provider, the Provider will pre-certify the services on your behalf.

If you use a non-participating Provider(s) and you fail to pre-certify the services with GHI, GHI will reduce your benefits for the services by fifty percent (50%).

d. **Eligible Providers**. In order to be eligible for benefits, you must receive services from a Provider that meets the criteria set forth below.

- Board Certification with documented experience in ART, reproductive endocrinology, or urology/andrology; and a
- Member of the Society of Assisted Reproductive Technology (SART) and who uses SART standards and criteria to track data; or
- Meet GHI's criteria for knowledge and expertise in infertility and in ART.

e. **Exclusions**. GHI will not cover the services and/or costs set forth below.

- Donor costs.
- Cryopreservation of the egg and sperm separately.
- A reversal of elective sterilization procedures.
- Cloning.
- Surrogacy.
- Self-monitoring fertility kits, such as ovulation predictor kits.
- Storage of an embryo.
- Maternity care. However, maternity care benefits may be covered under your hospital and/or medical/surgical coverage.
- If you are a covered female, your benefits under this rider do NOT include any procedures, items or services that are performed upon, retrieved from or rendered to the male except any semen preparation procedure, semen wash and analysis, semen testicular extraction and intra-cytoplasmic sperm injection.
- If you are a covered male, your benefits under this rider do NOT include any medical procedures, items or services that are performed upon, retrieved from or rendered to the female.

f. **Medications**. GHI will not cover medications associated with ART services. However, if GHI provides your prescription drug benefits, then GHI will cover medications associated with ART according to the terms that apply to other prescription drugs."

D. All other terms, conditions, limitations and exclusions of your Certificate apply, except as specifically amended by this rider.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER TO AMEND THE GHI SENIOR CARE BENEFITS FOR CITY OF NEW YORK EMPLOYEES AND RETIREES

EFFECTIVE APRIL 1, 2004

GROUP HEALTH INCORPORATED

This rider amends your GHI Certificate of Insurance. It deletes Paragraph 2(A) of the Section entitled "Medicare Eligible Coverage" and replaces it with the new Paragraph 2(A) set forth below.

"A. Covered Services. If you receive any of the services listed below, GHI will cover 20% of the reasonable charge as determined by Medicare, after Medicare has paid 80% of the reasonable charge after you meet the applicable Part B and GHI deductibles. You are not covered for the Medicare Part B (medical) deductible. After the Part B deductible has been met, Medicare will pay 80% of the reasonable charge of your covered service. After you meet an additional $50 deductible, GHI will pay the 20% balance. In certain instances, by operation of law, Medicare may reduce its payment below 80% of the Medicare reasonable charge. If this occurs, GHI will continue to reimburse you 20% of the Medicare reasonable charge. As a result, the total combined reimbursement by Medicare and GHI may be less than 100% of the Medicare reasonable charge. Charges in excess of the reasonable and customary standard set by Medicare are not covered. These charges are your responsibility. You must first file for your Medicare benefits before filing for your GHI benefits. When filing a GHI claim, please attach the Explanation of Medicare Benefits form to your GHI Claim Form. You are subject to the same standards of coverage listed throughout this Certificate. Please note that if you receive covered services from a Provider who accepts Medicare assignment or who participates with GHI, GHI will reimburse the Provider directly.

The following services are covered:

(1) Home and Office Visits (except for Chiropractic care).

(2) Surgery, Assistant Surgery, and the Administration of Anesthesia.

(3) Dental Surgery.

(4) Maternity Care.

(5) In-Hospital Medical Care.

(6) Radiation Therapy and Chemotherapy.

(7) Specialist Consultation.

(8) Diagnostic Procedures, X-ray examinations and Laboratory Tests.

(9) Shock Therapy.

(10) Intermittent Nurse Service is in your home (visiting nurse service).

Please note that routine foot care and psychiatric services are not covered. GHI does not provide coverage in those instances where Medicare denies coverage, except for services rendered outside of the United States of America."

All other terms, conditions, limitations and exclusions of your Certificate apply, except as specifically amended by this rider

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER FOR CITY OF NEW YORK EMPLOYEES AND RETIREES WHO ARE MEDICARE ELIGIBLE

GROUP HEALTH INCORPORATED

This rider amends your prescription drug coverage description set forth in your Contract or Certificate and any riders thereto as set forth below.

1. The section entitled "Optional Rider for Medicare Eligible Subscribers Covered Under Section Fourteen" is deleted in its entirety and replaced with the following new paragraph:

> Coverage, including copayments, coinsurance and deductibles, is as set forth in your City ofNew York Medicare Part D Prescription Drug Plan Evidence of Coverage (EOC). Your EOC will also explain how your Medicare Part D prescription drug coverage coordinates with other types ofprescription drug coverage you may have through another carrier or New York State, what type ofprescription drug payments count towards your out-of-pocket costs and how to file an appeal or grievance related to your prescription drug coverage.

2. Other Terms. All other terms, conditions, limitations and exclusions of your Contract, Certificate and/or rider apply.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER AMENDING THE GHI CERTIFICATE OF INSURANCE FOR CITY OF NEW YORK EMPLOYEES AND RETIREES

GROUP HEALTH INCORPORATED

This rider amends the GHI Certificate of Insurance for City of New York Employees and Retirees ("Certificate"). It changes the Behavioral Management Program (BMP) benefits for mental health care as set forth below effective on and after July 1, 2007.

A. This rider deletes subparagraph (2) entitled "Mental Health Benefits" from the "BMP – Covered Outpatient Treatment" terms that appear in Section Five, Paragraph 25 of the Certificate. It replaces this subparagraph with new subparagraph (2) set forth below.

"2. Mental Health Benefits.

A. Benefits. You are covered for outpatient mental health care. Mental health care refers to medically necessary care rendered by an eligible Provider and which, in the opinion of GHI, is directed predominately at treatable behavioral manifestations of a condition that GHI determines: a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and b) substantially or materially impairs a person's ability to function in one or more major life activities; and c) has been classified as a mental disorder in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders A Provider listed below must render the services.

- A facility issued an operating certificate by the New York State Commissioner of Mental Health or, outside of New York, a facility licensed or certified to provide the services in the state in which they are delivered or is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) to provide such services.
- A facility operated by the New York State Office of Mental Health.
- A licensed psychiatrist.
- A licensed psychologist.
- A licensed clinical social worker qualified for reimbursement. He or she must have at least six (6) years of post-masters' degree supervised psychotherapy experience.

The services may be rendered in a professional office, clinic, facility outpatient department or a university faculty practice corporation. GHI will not pay for the service unless it is rendered by one of the Providers set forth above. Services that are merely supervised or directed by such a Provider are not covered.

B. Number of Visits Covered. The number of visits that GHI will cover will vary. It will depend upon whether you receive services from a Participating or non-participating Provider.

- Participating Provider. GHI will cover an unlimited number of outpatient mental health visits per member per calendar year.
- Non-Participating Provider. GHI will cover up to thirty (30) outpatient mental health visits per member per calendar year. Group and individual visits count as one visit.

C. Payments. The amount of GHI's payment for covered services will vary. It will depend upon whether you receive services from a Participating or non-participating Provider, and by the type of Provider.

- **Participating Provider.** A Participating Provider has an agreement to provide care to covered persons. GHI will pay the Provider directly. Each visit is subject to the Co-pay Charge that applies to home and office visits under the Certificate, as amended from time to time.
- **Non-Participating Provider**. GHI will pay for covered services provided and billed by a non-participating provider or facility according to the same terms, conditions and maximums that apply to use of non-participating providers under Section Four of the Certificate, as amended from time to time, for home and office visits."

B. This rider deletes subparagraph (4) entitled "Treatment Plan" from the "BMP – Covered Outpatient Treatment" terms that appear in Section Five, Paragraph 25 of the Certificate. It replaces this subparagraph with new subparagraph (4) set forth below.

"4. Treatment Plan. All covered services must be medically necessary. A treatment plan must be pre-certified before you begin any covered outpatient treatment. Participating Providers will pre-certify your treatment plan. Participating

providers may not bill you for covered services that were not pre-certified. You must call the Clinical Referral Line to pre-certify non-emergency care rendered by non-participating Providers. To start the pre-certification process, please call the Clinical Referral Line at 1-800-NYC-CITY (1-800-692-2489). All care is reviewed for medical necessity."

C. This rider deletes subparagraph (5) entitled "Appeals" from the "BMP – Covered Outpatient Treatment" terms that appear in Section Five, Paragraph 25 of the Certificate. It replaces this subparagraph with new subparagraph (5) set forth below.

"5. Appeals. You may appeal if your treatment plan is not approved. To file an appeal, please call the Clinical Referral Line at 1-800-NYC-CITY (1-800-692-2489)."

D. This rider deletes subparagraph (2) entitled "Mental Health Benefits" from the "BMP – Covered Inpatient Treatment" terms that appear in Section Five, Paragraph 25 of the Certificate. It replaces this subparagraph with the new subparagraph (2) set forth below.

"**2. Mental Health Benefits**.

A. Benefits. You are covered for inpatient mental health care. Mental health care refers medically necessary care rendered by an eligible Provider and which, in the opinion of GHI, is directed predominately at treatable behavioral manifestations of a condition that GHI determines: a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and b) substantially or materially impairs a person's ability to function in one or more major life activities; and c) has been classified as a mental disorder in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

In New York State, you must receive care in a hospital as defined by Section 1.03(10) of the New York State Mental Hygiene Law. Outside of New York State, you must receive care in a facility that is licensed or certified to provide the type of care that you receive by the state in which the facility is located or is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) to provide such care.

B. Number of Days Covered. GHI will cover up to thirty (30) days of active inpatient treatment per member per calendar year. Two (2) partial hospitalization visits will count as one (1) inpatient day.

C. Payments. You must meet a deductible of $[300] per person per continuous confinement. After you meet the deductible, GHI will provide paid in full benefits for covered services received from a GHI participating or a non-participating facility. Care that has not been pre-certified is subject to a penalty of $1,000. In no event, however, will the penalty exceed fifty percent (50%) of the benefit otherwise payable. Once the amount of the inpatient mental health care deductibles you have incurred in a calendar year reaches $[750], then you will not be subject to more deductibles for inpatient mental health care services for the rest of that calendar year."

E. This rider deletes subparagraph (3) entitled "Mental Health Benefits" from the "BMP – Covered Inpatient Treatment" terms that appear in Section Five, Paragraph 25 of the Certificate. It replaces this subparagraph with the new subparagraph (3) set forth below.

"3. Pre-Certification Procedures. To be eligible for full benefits, you must pre-certify all non-emergency inpatient care before receiving services. To commence the pre-certification process, you must call the Clinical Referral Line at 1-800-NYC-CITY (1-800-692-2489).

- If your doctor recommends confinement, your care must be pre-certified prior to the admission date.
- If you are hospitalized due to an emergency, you should certify the care within one (1) business day of the admission. If you are not medically able to call within that time, you should call as soon as reasonably possible. An "emergency" is 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.

- Participating providers must pre-certify your care. They cannot bill you for covered services that are not pre-certified. You are responsible to pre-certify care rendered in a non-participating facility."

F. This rider adds the following new segment entitled "BMP - Additional Benefits for Biologically Based Mental Illness and Children with Serious Emotional Disturbances" to the end of Section Five, Paragraph 25 of the Certificate.

"Additional Benefits for Biologically Based Mental Illness and Children with Serious Emotional Disturbances.

A. Benefits. GHI will provide additional benefits as set forth below for covered services to diagnose and treat biologically based mental illness and for children with serious emotional disturbances. Biologically based mental illness refers to one (1) or more of the conditions listed below.

- Schizophrenia/psychotic disorders.
- Major depression.
- Bipolar disorder.
- Delusional disorders.
- Panic disorder.
- Obsessive-compulsive disorder.
- Bulimia.
- Anorexia.

Children with serious emotional disturbances refer to children less than eighteen (18) years of age with diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, together with one (1) or more of the following conditions:

- Serious suicidal symptoms or other life threatening self-destructive behaviors;
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Inpatient Services.

(i) **Number of Days Covered**. GHI will cover up to three hundred and sixty (365) days of inpatient mental health care services per single continuous confinement to diagnose and treat biologically based mental illness and children with serious emotional disturbances. Two (2) partial hospitalization visits will count as one (1) inpatient day.

(ii) **Payments**. You must meet a deductible of $[300] per person per continuous confinement. After you meet the deductible, GHI will provide paid in full benefits for covered services received from a GHI participating or a non-participating facility. Care that has not been pre-certified is subject to a penalty of $1,000. In no event, however, will the penalty exceed fifty percent (50%) of the benefit otherwise payable. Once the amount of the inpatient mental health care deductibles you have incurred in a calendar year reaches $[750], then you will not be subject to further deductibles for inpatient mental health care services for the rest of that calendar year.

Inpatient mental health care to diagnose and treat biologically based mental illness and children with serious emotional disturbances count toward the number of inpatient mental health care services available under this Paragraph 25, but are not subject to that inpatient day maximum. For inpatient mental health services received

from non-participating Providers, you must pre-certify care before receiving services. To start the pre-certification process, please call the Clinical Referral Line at 1-800-NYC-CITY (1-800-692-2489). Care that is not pre-certified is subject to a penalty of $1,000. In no event, however, will the penalty exceed fifty percent (50%) of the benefit otherwise payable.

C. Outpatient Services. GHI will provide benefits for outpatient mental health care services to diagnose and treat biologically based mental illness and for children with serious emotional disturbances. A Provider listed below must render the services.

- A facility that is certified by the New York State Commissioner of Mental Health or, outside of New York, a facility licensed or certified to provide the services in the state in which they are delivered or is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) to provide such services.
- A facility operated by the New York State Office of Mental Health.
- A psychiatrist.
- A registered or certified psychologist.
- A certified social worker. The social worker must be qualified as a Provider for third-party reimbursement under the laws of New York State. He or she must have six (6) years of post-masters' degree supervised psychotherapy experience.

(i) **Number of Visits Covered**. GHI will cover outpatient mental health visits to diagnose and treat biologically based mental illness and children with serious emotional disturbances. Such visits count toward the number of outpatient mental health visits otherwise available under this Paragraph 25, but are not subject to that outpatient visit maximum.

(ii) **Payments**. The amount of GHI's payment for covered services will vary. It will depend upon whether you receive services from a Participating or non-participating Provider.

- **Participating Provider**. A Participating Provider has an agreement to provide care to covered persons. GHI will pay the Provider directly. Each visit is subject to the Co-pay Charge that applies to home and office visits under the Certificate, as amended from time to time.
- **Non-Participating Provider**. GHI will pay for covered services provided and billed by a non-participating provider or facility according to the same terms, conditions and maximums that apply to use of non-participating providers under Section Four of the Certificate, as amended from time to time, for home and office visits."

G. This rider changes the heading of paragraph 2(b) of the Optional Rider for Active Employees and Non-Medicare Eligible Retirees that appears in the Certificate. It replaces the current heading "Psychiatric Care and Chemical Dependency" with the new heading "Chemical Dependency."

H. This rider deletes paragraph 2(b)(1) of the Optional Rider for Active Employees and Non-Medicare Eligible Retirees that appears in the Certificate.

I. All other terms, conditions, limitations and exclusions of the Certificate apply to this rider.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

Rider to Group Insurance Certificate Replacing Section entitled "CONTINUATION OF COVERAGE"

GROUP HEALTH INCORPORATED

This rider amends your Certificate of Insurance with GHI. It replaces the section entitled "CONTINUATION OF COVERAGE" as set forth below:

CONTINUATION OF COVERAGE.

1. Continuation of Coverage. For the purpose of this section, a Group Member is defined as an employee or retiree to whom coverage is made available. Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), continuation of current group benefits may be available after loss of eligibility for coverage. Group Members, their spouses and their dependent children as well as any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage may be eligible for continuation. In order to qualify for continuation of coverage, you must no longer be eligible for health care benefits because of any of the following qualifying events:

- Termination of employment.
- A decrease in benefits due to a reduction in hours of employment.
- Loss of coverage because of a divorce; legal separation; or the death of the Group Member.
- Loss of eligibility for coverage as a dependent of a Group Member.
- Loss of Coverage of the spouse and dependents when a covered employee or a covered retiree becomes entitled to Medicare.
- Loss of eligibility for coverage as a covered retiree or covered spouse, dependent, or widow of a retiree whose employer filed for bankruptcy on or after July 1, 1986.

This coverage is available without evidence of insurability. Continuation is not available for certain non-resident aliens. However, these non-resident aliens may be entitled to continuation of coverage as provided under New York State law. See Paragraph 2 below. If you have a question regarding your status for eligibility to continue coverage under Federal law, kindly contact your group.

Continuation of coverage is subject to the following conditions:

(a) COBRA continuation coverage is not available if you are covered under the group health plan by reason of another individual's election of COBRA continuation coverage and you are not already a qualified beneficiary by reason of a prior qualifying event. COBRA continuation of coverage is not available if you become covered by another group policy that provides similar benefits. Unless, that policy contains a pre-existing condition limitation. COBRA continuation of coverage is also not available if the reason for termination of employment was gross misconduct. However, if you were terminated due to gross misconduct you may be entitled to a continuation of coverage. This is provided under New York State law. See Paragraph 2 below.

(b) A Group Member, spouse, or dependent child must notify the Plan of a divorce, legal separation, or change in dependent status. This notice must be sent to the Plan within sixty (60) days of the later of either of the following:

(i) The date of the qualifying event.

(ii) The date coverage would otherwise be lost.

(c) You must request continuation of coverage in writing within sixty (60) days of the later of either of the following:

(i) The date your coverage would otherwise terminate under your group Plan.

(ii) The date notice of your right to continue coverage is sent to you.

(d) You must pay your group contract holder one hundred and two percent (102%) of the group rate for continuation of coverage. The required premium includes two percent (2%) of the group rate to cover administration costs. If you are disabled and extend coverage from eighteen (18) to twenty-nine (29) months, you must pay a different premium for the Nineteenth (19th) through twenty-ninth (29th) month. You must pay your group contract holder one hundred and fifty percent (150%) of the group rate for the continuation of coverage. This premium may be collected on a monthly basis.

(e) Your continuation of coverage will terminate on the first of the following date.

(i) You become entitled to Medicare benefits after the date of the COBRA election. You become entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

(ii) You become covered under another group health care plan as an employee or dependent after the date of the COBRA election. Unless that plan contains a pre-existing condition, limitation and you had a break in coverage of more than sixty-three (63) days;

(iii) Eighteen (18) months, if the qualifying event is termination of employment or reduction of hours, unless you are disabled, as determined by Social Security. The eighteen (18) months will be measured from the date of the qualifying event. Your Plan may elect to measure the eighteen (18) months from loss of coverage;

(iv) Twenty-nine (29) months after termination of employment or reduction of hours if you are disabled. The twenty-nine (29) months will be measured from the date of the qualifying event. Your plan may elect to measure twenty-nine (29) months from the loss of coverage. You must be disabled as determined by Social Security. You must be disabled on the date of termination of employment or reduction of hours or become disabled within sixty (60) days of termination of employment. You must notify your Plan of Social Security's determination of your disability. The notice must be provided within sixty (60) days of Social Security's determination and before the end of the eighteen (18) month continuation period. If Social Security determines that you are no longer disabled, you must notify the plan administrator of this. You must notify the plan administrator of this within thirty (30) days from Social Security's final determination. If you are no longer disabled, COBRA continuation coverage may terminate earlier than twenty-nine (29) months for you and your qualified beneficiaries.

(v) Thirty-six (36) months for all other qualifying events. The thirty-six (36) will be measured from the date of the qualifying event. You may elect to measure the thirty-six (36) months from the loss of coverage;

The end of the period for which you made premium payments, if you fail to make timely payment of the required premium;

(vii) The date on which your group plan terminates coverage with GHI. However if the group plan is replaced by the group contract holder with similar coverage, you have the right to become covered under the other coverage for the balance of the period that you would have remained covered hereunder; or

(viii) At any time that your coverage is terminated for cause.

An eighteen (18) month period of continuation may be extended to a thirty-six (36) month period if a second qualifying event occurs during the eighteen (18) month period. The second qualifying event must be of the type that would allow the covered Group Member or his or her dependents to continue coverage for thirty-six (36) months. The thirty-six (36) month period in this case will be measured from the first qualifying event.

Your Plan may elect to calculate your period of continuation coverage from the date of loss of coverage instead of the date of the qualifying event. Contact your group to determine whether the group has elected this option. This option is not available if the loss of coverage occurs because a covered employee becomes entitled to Medicare. In such a case, the period of continuation coverage for the spouse and dependents begin the date the covered employee becomes entitled to Medicare.

When your continued coverage terminates, you may purchase a direct payment conversion contract from GHI. (See Direct Payment Conversion Section).

2. Continuation of Coverage under New York State Law. There are cases where you may lose eligibility for coverage under this Certificate but not be eligible for continuation of coverage under Federal law. If the loss of eligibility is due to termination of employment or loss of membership in the class or classes eligible for coverage, you may be entitled to continue coverage under New York State law. Continued coverage is available without evidence of insurability. If continuation is available to the Group member under Federal law, then the New York State continuation law does not apply. A spouse or dependent of a Group Member does not have a separate right to elect continuation of coverage under New York State law if continuation is

available to the Group Member under Federal Law. The New York State law does not apply if you become eligible for coverage under Medicare or another group health policy.

The following criteria apply to New York State continuation of coverage:

(a) Continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. Continuation of coverage is also not available if you become covered or could be covered by another group policy that provide similar benefits. Unless that policy contains a pre-existing condition limitation.

(b) You must request continuation of coverage in writing and submit your first premium payment within sixty (60) days of the later of either of the following:

(i) The date your coverage would otherwise terminate under your group Plan.

(ii) The date notice of your right to continue coverage is provided to you.

(iii) The member who wants to continue coverage due to disability.

(c) You must pay your group contract holder one hundred and two percent (102%) of the group rate for continuation of coverage. But not more frequently than on a monthly basis in advance.

(d) Your continuation of coverage will terminate on the first of the following dates:

(i) You become eligible for Medicare.

(ii) You become covered under another group health care plan as an employee or dependent, unless that plan contains a pre-existing condition limitation.

(iii) Eighteen (18) months, if the qualifying event is termination of employment or membership in the class or classes eligible for coverage.

(iv) Twenty-nine (29) months after termination of employment or membership in the class or classes eligible for coverage if you are disabled. The twenty-nine (29) months will be measured from the date coverage would otherwise be lost. You must be disabled as determined by Social Security. You must be disabled on the date of termination of employment or membership or become disabled within the first sixty (60) days of continuation of coverage. You must notify your Plan of Social Security's determination of your disability. If you are no longer disabled, continuation coverage will terminate on the later of the following:

- Eighteen (18) months from the date coverage would otherwise be lost.
- The month that begins more than thirty-one (31) days after Social Security determines that you are no longer disabled.

(v) Thirty-six (36) months if you are an eligible dependent who will otherwise lose coverage due to the death of the Group Member, divorce, legal separation, change in dependent status or the Group Member becoming eligible for Medicare. The thirty-six (36) months will be measured from the date coverage would otherwise be lost.

(vi) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

(vii) The date on which your group plan terminates coverage with GHI. However, if the group plan is replaced by the group contract holder with similar coverage, you have the right to become covered under the other coverage for the balance of the period that you would have remained covered hereunder. The replacement plan must provide at least the same level of benefits provided by the prior group plan, reduced by any benefits payable under the prior group contract. The prior group plan must provide benefits to the extent of its accrued liabilities and extension of benefits.

When your continued coverage terminates, you may purchase a direct payment conversion contract from GHI. (See Direct Payment Conversion Section).

3. Special Provisions for Members of the Armed Forces on Active Duty. If the Group Member is a member of a reserve component of the armed forces of the United States. This includes the National Guard, and on active duty, you may be entitled to:

(a) Supplementary continuation of current group benefits under New York State law and conversion to a direct payment contract from GHI upon termination of continued coverage. (See Paragraph A below); or

(b) Suspension of coverage during the period of active duty. (See Paragraph D below.)

A. Eligibility. In order to be eligible for the rights set forth in this Paragraph 3, the Group must not voluntarily maintain coverage for the Group Member during the period of active duty. Also, the Group Member must have:

(a) Voluntarily or involuntarily entered active duty (other than to determine physical fitness or for training); or

(b) Had his or her active duty voluntarily or involuntarily extended. This must occur during a period when the President of the United States is authorized to order units of the ready reserve or member of a reserve component to active duty. The extended active duty must be at the request and for the convenience of the federal government; and;

(c) Served no more than four years of active duty.

B. Supplementary Continuation of Coverage. If your group does not voluntarily maintain coverage for the Group Member during the period of active duty, you are eligible for supplementary continuation of coverage under the group contract. This supplementary continuation of coverage is available without evidence of insurability. Coverage available through the Federal government for active duty members and their families shall not be considered group coverage.

You must apply for supplementary continuation within sixty (60) days of being ordered to active duty. You must pay one hundred percent (100%) of the group premium on a monthly basis. But not more frequently than on a monthly basis in advance.

Continuation of coverage is not available if you are covered under Medicare or could be covered under Medicare. It is also not available if you become covered by another group policy.

The condition must have arose during the period of active duty and the condition has been determined by the secretary of veteran affairs to be a condition incurred in the line of duty.

In certain circumstances, supplementary continuation may terminate earlier. Continuation of coverage will terminate earlier on the first of the following dates:

(i) You become eligible for Medicare.

(ii) You become covered under another group health care plan as an employee or dependent.

(iii) The end of the period for which you made premium payments, if you fail to make timely payment of the required premium.

(iv) The date on which the group plan terminates coverage with GHI. However, if your group replaces the Group Contract with similar coverage, you have the right to become covered under that other coverage for the balance of the period that you would have remained covered hereunder.

(v) The Group Member has served four years of active duty.

If the Group Member dies while on active duty, supplementary continuation of coverage will terminate for the surviving spouse and covered dependents of the Group Member. In the event of divorce or annulment of the marriage to the Group Member, supplementary continuation of coverage will terminate for the former spouse. In these circumstances, the former spouse and the surviving spouse and covered dependents are eligible for conversion. (See Paragraph C below.)

When the group Member returns to civilian status and he or she is re-employed or restored to participation in the group, coverage under the group plan will be resumed. Supplementary continuation of coverage will terminate on the date that coverage under the group plan becomes effective. Coverage will not be subject to limitations, conditions, exclusions, or waiting periods unless:

(a) A waiting period was imposed and had not been completed prior to the period of suspension; or

(b) The Group Member's condition arose during the period of active duty and was incurred in the line of duty.

However, in no event shall the sum of the waiting periods imposed prior to and subsequent to the period of suspension shall not exceed the length of the waiting period originally imposed.

When the Group Member returns from active duty and does not become re-employed or restored to participation in the group, the Group Member shall be entitled to:

(a) Continue coverage under New York State Law and purchase a direct payment conversion contract from GHI upon termination of continued coverage. (See Paragraph 2 of this Section.) or;

(b) Purchase a direct payment conversion contract from GHI. (See Section Direct Payment Conversion Section).

C. Conversion.

(a) **Availability**. When your supplementary continuation of coverage terminates, you may purchase a direct payment contract from GHI. Conversion is available to the former spouse of a Group Member upon divorce or annulment of the marriage of the Group Member. The divorce or annulment must have occurred while the Group Member was on active duty. In addition, conversion is available to the surviving spouse and other dependents covered under the contract upon the death of the Group Member. The death must have occurred during the Group Member's active duty. Conversion is also available to a dependent who is no longer within the definition of family under the contract while the Group Member is on active duty.

(b) **When to Apply for the New Conversion Contrac**t. You must apply for the new contract within thirty-one (31) days of the later of the following:

(i) The date the Group Member's active duty terminates; or

(ii) The date the Group Member is discharged from the Hospital. The hospitalization must have resulted from active duty. It cannot exceed one (1) year.

Payment of the first premium must be made at the time you apply for the direct payment contract.

D. Suspension of Coverage. If the group does not voluntarily maintain coverage for the Group Member and you do not continue your group benefits, your coverage will be suspended during the period of active duty. When the Group Member returns to participation in the group plan, coverage under the group plan will be resumed. Coverage will be retroactive to the date active duty terminated. Coverage will not be subject to limitations, conditions, exclusions, or waiting periods unless:

(a) A waiting period was imposed and had not been completed prior to the period of suspension; or

(b) The condition must have arose during the period of active duty and the condition has been determined by the secretary of veteran affairs to be a condition incurred in the line of duty.

However, in no event shall the sum of the waiting periods imposed prior to and subsequent to the period of suspension shall not exceed the length of the waiting period originally imposed.

If the Group Member returns from active duty and does not become re-employed or restored to participation in the group, the Group Member shall be entitled to:

(a) Continue coverage under New York State Law and purchase a direct payment conversion contract from GHI upon termination of continued coverage. (See Paragraph 2 of this Section.); or

(b) Purchase a direct payment conversion contract from GHI. (See Direct Payment Conversion Section).

4. Questions. The laws regarding continuation of benefits are complicated. If your coverage under this Certificate is terminating, you should contact your Group if you are interested in continuing your benefits.

Other Terms. All other terms, conditions, limitations and exclusions of your Certificate apply.

GROUP HEALTH INCORPORATED

(hereinafter referred to as "GHI")

441 Ninth Avenue, New York NY 10001

RIDER TO AMEND
GHI PROCEDURES FOR DETERMINATION OF CLAIMS, GRIEVANCES & APPEALS

GROUP HEALTH INCORPORATED

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This rider amends your GHI Contract or Certificate of Insurance. Among other changes, it sets forth GHI's new procedures for handling claims. It also gives you instructions about how to file grievances, internal appeals and external appeals.

1. This rider deletes the paragraph(s) entitled "Criteria for Coverage" from Section One, and replaces it with the new paragraph(s) set forth below.

"**Criteria for Coverage**. In order to request benefits, you must file a claim with GHI.

You, your authorized representative or your provider may file a claim for benefits with GHI on your behalf. For information about how to file a claim, please see the section of your Contract or Certificate entitled "Filing of Claims" or "Filing of Claims and Appeals."

GHI will provide benefits only for the services that are listed as covered in this Contract or Certificate. GHI will cover these services only if they are medically necessary and not otherwise excluded from coverage. The services must also be rendered by an eligible Provider.

Medically necessary services are health care services that are rendered by a Hospital or a licensed Provider and are determined by GHI to meet all of the criteria listed below.

- They are provided for the diagnosis, or direct care or treatment of the condition, illness, disease, injury or ailment.
- They are consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- They are in accordance with accepted standards of good medical practice in the community.
- They are furnished in a setting commensurate with the patient's medical needs and condition.
- They cannot be omitted under the standards referenced above.
- They are not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- They are not furnished primarily for the convenience of the patient, the patient's family or the Provider.
- In the case of a hospitalization, the services cannot be rendered safely or adequately on an outpatient basis and, therefore, require that the patient receive acute care as a bed patient."

"Utilization Review Decisions.

Utilization review is the process by which GHI decides whether or not an item or service for which you have requested benefits is medically necessary and/or experimental or investigational in nature. Utilization review is performed under the supervision of GHI's Medical Director. A clinical peer reviewer will confirm each finding by GHI that an item or service is not medically necessary or that an item or service is experimental or investigational and, therefore, not covered.

GHI will notify you of utilization review decisions as set forth below. If you disagree with GHI's decision that an item or service(s) is not medically necessary or is experimental or investigational in nature and therefore, not covered, you may file an appeal. Please see paragraph 2(C) of this rider for instructions on how to file an appeal.

Pre-Service Claims. A "pre-service claim" is a claim for a service that you must pre-certify with GHI under the terms of this Contract or Certificate. GHI will notify you and your Provider of its decision on a pre-service claim within the earlier of three (3) business days or five (5) calendar days after GHI's receipt of the claim. GHI will notify you in writing and by telephone.

If GHI requires more information to decide your claim, GHI will request such information within fifteen (15) days after its receipt of the claim. GHI will give you at least forty-five (45) days to supply the information. If you supply all of the requested information to GHI within the time that GHI gives you to supply it, then GHI will notify you of its decision within three (3) business days, but not later than five (5) calendar days after its receipt of the information. Otherwise, GHI will notify you of its decision within fifteen (15) days of its receipt of partial information or within fifteen (15) days of the end of the time period GHI gives you to supply it.

If you fail to pre-certify a service when it is required by this Contract or Certificate, GHI will inform you of the proper pre-certification procedure within five (5) days (or within twenty-four (24) hours in the case of a pre-service urgent care claim) of receipt of the claim by a GHI person or unit customarily responsible for handling benefit matters.

Post-Service Claims. A post service claim refers to any claim for benefits relating to a service that has already been provided to you. GHI will notify you, and if appropriate your provider, of its decision on a post-service claim within thirty (30) days after its receipt of the claim. GHI will notify you in writing.

If GHI requires more information to decide your claim, GHI will request such information within thirty (30) days after its receipt of the claim. GHI will give you at least forty-five (45) days to supply the information. If GHI requests more information, GHI will notify you of its decision on your claim within fifteen (15) days after GHI's receipt of all or part of the information or within fifteen (15) days after the end of the time period GHI gives you to supply the information.

Urgent Care Claims. An urgent care claim refers to a claim that, if subjected to the other time periods set forth in this section, could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately. GHI may reasonably require you or your provider to explain the medical reasons that give rise to a need for urgent care.

If care has **not** yet been initiated, GHI will notify you and your provider of its decision on your urgent care claim within seventy-two (72) hours from receipt of the claim. GHI will notify you in writing and by telephone. If GHI requires more information to make a decision, GHI will notify you of the required information within twenty-four (24) hours after GHI's receipt of the claim. GHI will give you at least forty-eight (48) hours to supply the information. GHI will notify you of its decision on your claim within forty-eight (48) hours of its receipt of the information or within forty-eight (48) hours of the end of the time period GHI gives you to supply the information.

If care has already been initiated and you are seeking an extension of urgent care, the time in which GHI will decide your urgent care claim will vary. It will depend upon when GHI receives your claim. If GHI receives your claim at least twenty-four (24) hours before the end of the previously approved treatment plan, then GHI will notify you and your provider of its decision on your urgent care claim within twenty-four (24) hours after GHI's receipt of the claim. If GHI receives your claim less than twenty-four (24) hours before the end of the previously approved treatment plan, then GHI will notify you and your provider of its decision within the earlier of one (1) business day of its receipt of all necessary information or seventy-two (72) hours of its receipt of the claim. GHI will notify you in writing and by telephone.

Concurrent Care Decisions. A concurrent care decision refers to a claim decision by GHI that affects an on-going course of treatment taking place over a period of time or a number of treatments. If you or your provider request a non-urgent continuation, extension or addition to a previously approved plan of care, GHI will notify you and if appropriate, your provider of its decision within one (1) business day of GHI's receipt of all necessary information, but not more than fifteen (15) days after GHI's receipt of the claim. If GHI reduces or terminates a previously approved course of treatment (for reasons other than amendment or termination of this Contract or GHI your coverage), GHI will notify you and if appropriate, your provider of its decision sufficiently in advance so that you that you can appeal the decision. GHI will notify you in writing and by telephone."

"**Other Claim Decisions**.

If your claim does not involve a determination by GHI regarding the medical necessity or experimental or investigational nature of the requested service(s), GHI will notify you of its decision on your claim as set forth below.

Pre-Service Claims. A "pre-service claim" is a claim for a service that you must pre-certify with GHI under the terms of this Contract or Certificate. GHI will notify you and your Provider of its decision on a pre-service claim within fifteen (15) days after GHI's receipt of the claim. GHI will notify you in writing.

If GHI requires more information to decide your claim, GHI will request such information within fifteen (15) days after its receipt of the claim. GHI will give you at least forty-five (45) days to supply the information. If GHI requests more information,

GHI will notify you of its decision on your claim within fifteen (15) days after its receipt of all or part of the information or within fifteen (15) days after the end of the time period GHI gives you to supply it.

If you fail to pre-certify services when it is required by this Contract or Certificate, GHI will inform you of the proper pre-certification procedures within five (5) days (or within twenty-four (24) hours in the case of a pre-service urgent care claim) of receipt of the claim by a GHI person or unit customarily responsible for handling benefit matters.

Post-Service Claims. A post service claim refers to any claim for benefits that is not a pre-service claim. GHI will notify you of its decision on a post-service claim within thirty (30) days of its receipt of the claim. GHI will give such notice in writing.

If GHI requires more information to decide your claim, GHI will request such information within thirty (30) days after its receipt of the claim. GHI will give you at least forty-five (45) days to supply the information. If GHI requests more information, GHI will notify you of its decision on your claim within fifteen (15) days after the earlier of GHI's receipt of all or part of the information or the end of the time period GHI gives you to supply it. GHI may combine its request for more information with a notice of denial. If GHI does not receive any information, then this denial will apply. In such a case, you will not receive a notice from GHI at the end of the time period GHI gives you to supply information.

If you receive services from a GHI participating provider, and your only liability for the service(s) is a Co-pay Charge, then the time periods above do not apply.

Urgent Care Claims. An urgent care claim refers to a claim that, if subjected to the other time periods set forth in this section, could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or subject the patient to severe pain that cannot be managed adequately. GHI may reasonably require you or your provider to explain the medical reasons that give rise to a need for urgent care.

If care has not yet been initiated, GHI will notify you of its decision on your urgent care claim within seventy-two (72) hours of its receipt of the claim. If care has already been initiated and you are seeking an extension of urgent care, the time in which GHI will decide your urgent care claim will vary. It will depend upon when GHI receives your claim. If GHI receives your claim at least twenty-four (24) hours before the end of the previously approved treatment plan, then GHI will notify you of its decision on your urgent care claim within twenty-four (24) hours after GHI's receipt of the claim. If GHI receives your claim less than twenty-four (24) hours before the end of the previously approved treatment plan, then GHI will notify you and your provider of its decision within seventy-two (72) hours of its receipt of the claim. GHI will provide such notice in writing.

If GHI requires more information to make a decision on your urgent care claim, GHI will notify you of the required information within twenty-four (24) hours after GHI's receipt of the claim. If GHI requests more information, GHI will give you at least forty-eight (48) hours to supply the information. GHI will notify you of its decision on your claim within forty-eight (48) hours of the earlier of its receipt of the information or the end of the time period GHI gives you to supply the information.

Concurrent Care Decisions. A concurrent care decision refers to a claim decision by GHI that affects an on-going course of treatment taking place over a period of time or a number of treatments. If you or your provider request a non-urgent continuation, extension or addition to a previously approved plan of care, GHI will notify you of its decision within fifteen (15) days from GHI's receipt of the claim. If GHI reduces or terminates a previously approved course of treatment (for reasons other than amendment or termination of this Contract or your GHI coverage), GHI will notify you of its decision sufficiently in advance so that you that you can appeal the decision. GHI will give such notice in writing."

2. This rider amends the section of your Contract or Certificate entitled "Filing of Claims" or "Filing of Claims and Appeals." It adds the new terms set forth below to that section. Any terms that appear in that section of your Contract or Certificate that are not consistent with the new terms below are hereby deleted from your Contract or Certificate.

"**A. GRIEVANCES**.

If you do not agree with a decision made by GHI (other than a decision regarding the medical necessity or experimental or investigational nature of a requested service), you may file a grievance with GHI. You may also file a grievance with GHI if you

are not satisfied with one or more aspects of this GHI insurance program. You may authorize a representative to file a grievance on your behalf. You must file the grievance within one hundred and eighty (180) days from the date that you received notice of GHI's decision.

Your grievance must include your GHI identification number and claim number(s). It must also describe your complaint. It should also include any other information that you wish GHI to consider.

Please send your grievance(s) to:

GHI - Grievance Unit
P.O. Box 4007
New York, New York 10116-4007

GHI will reply to your grievance in writing. GHI will reply to your grievance within the time period(s) set forth below.

Urgent Care Claims: seventy-two (72) hours after GHI's receipt of the grievance

Pre-Service Claims: thirty (30) days after GHI's receipt of the grievance.

Post Service Claims and Other Grievances: sixty (60) days after GHI's receipt of the grievance.

B. YOUR PROVIDER'S RIGHT TO RECONSIDERATION.

If GHI denies a covered service on the basis that it is not medically necessary or it is experimental or investigational in nature, and GHI does not first try to discuss the decision with your Provider, your Provider has the right to request a reconsideration by GHI. If you have not yet received the service, GHI will reconsider the decision within one (1) business day of GHI's receipt of the request.

C. INTERNAL APPEALS.

STANDARD APPEALS. If GHI denies a claim for a covered service on the basis that the service is not medically necessary or is experimental or investigational in nature, you may file an appeal with GHI. You may also authorize a representative to file an appeal on your behalf. You may file the appeal by telephone or in writing. You must file the appeal within one hundred and eighty (180) days from the date that you receive notice of GHI's denial. The appeal must include your GHI identification number and claim number(s). It should also include any medical data and comments in support of your appeal.

You must file a verbal appeal by calling GHI toll free at:
1-888-906-7668.

You must direct written appeals to:

GHI - Utilization Review Appeals
P.O. Box 2809
New York, New York 10116-2809

GHI will acknowledge receipt of your appeal within fifteen (15) days of GHI's receipt of your appeal. If GHI needs more information to decide your appeal, GHI will also notify you and your Provider of the needed information within fifteen (15) days of GHI's receipt of the appeal. The time within which GHI must respond to your appeal will vary depending upon the type of claim that you are appealing. If GHI fails to decide your appeal within these time periods, the service will be deemed approved.

Pre-Service Claim Appeals. In the case of a pre-service claim, GHI will decide your appeal within thirty (30) days from GHI's receipt of the appeal.

Post-Service Claim Appeals. In the case of a post-service claim, GHI will decide your appeal within thirty (30) business days of GHI's receipt of all necessary information, but not more then sixty (60) days from GHI's receipt of the appeal.

Urgent Care Claim Appeals. In the case of an urgent care claim, GHI will decide your appeal within the earlier or two (2) business days of GHI's receipt of all necessary information or seventy-two (72) hours after GHI's receipt of the appeal.

Concurrent Care Appeals. If you are appealing GHI's denial of a non-urgent continuation, extension or addition to the care plan, GHI will decide your appeal within the earlier of two (2) business days of GHI's receipt of all necessary information or thirty (30) days after GHI's receipt of the appeal. If you are appealing GHI's reduction or termination of a previously approved care plan, GHI will decide your appeal within seventy-two (72) hours of GHI's receipt of the appeal.

EXPEDITED APPEALS. GHI offers an expedited appeal process in certain cases. An expedited appeal may be filed only in the cases below.

- Cases that involve continued or extended health care services, procedures or treatments.
- Cases that involve requests for additional services for a person undergoing a course of continued treatment.
- Cases where the Provider believes an immediate appeal is warranted due to imminent or serious threat to the health of the person.

If GHI needs more information to decide your appeal, GHI will notify you and your Provider of the needed information within twenty-four (24) hours. GHI will make a decision on your appeal within two (2) business days of GHI's receipt of the information needed for GHI to conduct a full and fair review, but not more than seventy-two (72) hours from GHI's receipt of the appeal. If GHI fails to decide your appeal within these time periods, the service will be deemed approved.

To file an expedited appeal, please call GHI toll free at 1-888-906-7668.

D. EXTERNAL APPEALS.

YOUR RIGHT TO AN EXTERNAL APPEAL.

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if GHI has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative may appeal that decision to an External appeal Agent, an independent entity certified by the State to conduct such appeals.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY.

If GHI has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following two (2) criteria:

- The service, procedure or treatment must otherwise be a Covered Service under this Contract or Certificate; and
- You must have received a final adverse determination through GHI's internal appeal process and GHI must have upheld the denial or you and GHI must agree in writing to waive any internal appeal.

YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL.

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Contract or Certificate; and
- You must have received a final adverse determination through GHI's internal appeal process and GHI must have upheld the denial or you and GHI must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A "life-threatening condition or disease" is one, which, according to the current diagnosis of your attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen (18), a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by GHI or one for which there exists a clinical trail (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to threat your life-threatening or disabling condition or disease.

THE EXTERNAL APPEAL PROCESS.

If, through GHI's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and GHI have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. GHI will provide an external appeal application with the final adverse determination issued through GHI's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from New York State at 1-800-400-8882. Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which GHI based its denial, the External Appeal Agent will share this information with GHI in order for it to exercise its right to reconsider its decision. If GHI chooses to exercise this right, GHI will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), GHI does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or GHI. If the External Appeal Agent requested additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and GHI by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, GHI will provide coverage subject to the other terms and conditions of this Contract or Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, GHI will only cover the costs of services required to provide treatment to you according to the design of the trial. GHI shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Contract or Certificate for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and GHI. The External Appeal Agent's decision is admissible in any court proceeding.

GHI will charge you a fee for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. GHI will also waive the fee if GHI determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

YOUR RESPONSIBILITES.

It is your REPONSIBILITY to initiate the external appeal process. You (or your designee) may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. In the case of a final adverse determination on a post-service claim, your physician may file an external appeal application, but only if you have consented to this in writing.

Under New York State law, your completed request for appeal must be filed within forty-five (45) days of either the date upon which you receive written notification from GHI that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. GHI has no authority to grant an extension of this deadline."

3. All other terms of your Contract or Certificate apply except to the extent that they conflict with the terms of this rider.

SECTION III

Additional Program Information

The following pages are not part of your GHI City of New York CBP Certificate of Insurance. However they provide important information about your health insurance program

Out-Of-Network Reimbursement Examples For GHI CBP

This summary gives examples of typical costs for out-of-network services under the GHI CBP plan in Richmond County for zip code 10314. If you want details about your coverage and costs, you can get the complete terms in the policy or plan document at **emblemhealth.com/city** or by calling us at **1-800-624-2414**.

COLONOSCOPY
(Biopsy of Large Bowel Using an Endoscope)
CPT Code: 45380
Anesthesia CPT Code: 00810
Pathology CPT Code: 88305

Sample care costs:		
	UCR	**Basic NYC Non-Participating Fee Schedule**
Hospital Services†	Not Applicable	Not Applicable
Physician Services	$1,200	$574
Anesthesia	$3,200	$873*
Pathology	$410	$56
Total	**$4,810**	**$1,503**

Patient pays:	
Deductibles	$200
Copays Are Not Applicable	$0
Coinsurance 0%	$0
Difference between UCR and what the plan pays	$3,307
Total	**$3,507**

LAMINOTOMY
(Partial Removal of Bone with Release of Spinal Cord or Spinal Nerves of 1 Interspace in Lower Spine)
CPT Code: 63030
Anesthesia CPT Code: 00630

Sample care costs:		
	UCR	**Basic NYC Non-Participating Fee Schedule**
Hospital Services†	Not Applicable	Not Applicable
Physician Services	$34,000	$6,183
Anesthesia	$3,610	$1,746**
Total	**$37,610**	**$7,929**

Patient pays:	
Deductibles	$200
Copays Are Not Applicable	$0
Coinsurance 0%	$0
Difference between UCR and what the plan pays	$29,681
Total	**$29,881**

BREAST RECONSTRUCTION
(Insertion of Tissue Expander in Breast)
CPT Code: 19357
Anesthesia CPT Code: 00402

Sample care costs:		
	UCR	**Basic NYC Non-Participating Fee Schedule**
Hospital Services†	Not Applicable	Not Applicable
Physician Services	$10,000	$4,297
Anesthesia	$3,154	$1,455**
Total	**$13,154**	**$5,752**

Patient pays:	
Deductibles	$200
Copays Are Not Applicable	$0
Coinsurance 0%	$0
Difference between UCR and what the plan pays	$7,402
Total	**$7,602**

†Hospital services are covered by Empire Blue Cross/Blue Shield. They are not covered under the GHI CBP.

*Based on 4 units of anesthesia

** Based on 10 units of anesthesia

UCR (usual and customary cost) is the amount providers typically charge for a service. This chart uses UCR based on FAIR Health at the 80th percentile for zip code 10314. Your provider may bill more than UCR.

The **Patient pays** section represents sample cost-sharing. Your cost-sharing may vary.

GHI
www.ghi.com

EMPIRE BLUECROSS BLUESHIELD

July 1999

Dear City of New York Employees or Non-Medicare Eligible Retirees:

We are pleased to announce a number of significant improvements to your Empire Blue Cross Blue Shield and GHI Comprehensive Benefits Plan (CBP). Through the joint efforts of the City of New York Office of Labor Relations and the City's unions, represented by the Municipal Labor Committee, you and your eligible dependents will enjoy the following program enhancements:

Dependent Student Coverage

Effective May 1, 1999, unmarried full-time dependent students, attending an accredited college or university, are covered for both hospital and medical care until the end of the calendar year in which the dependent reaches age 23 or graduation, whichever occurs first. Students are entitled to the same coverage as the subscriber. Students or family members must call NYC Healthline at 1-800-521-9574 prior to any scheduled hospital admission, or any elective non-emergency hospital admission at least 10 days before the admission, and within 24 hours after an emergency admission, to maintain their full health insurance benefits.

Empire Blue Cross Blue Shield Hospitalization Benefits

Effective July 1, 1999

Skilled Nursing Facility/Rehabilitation Benefits

Empire Blue Cross Blue Shield provides a flexible Combined Skilled Nursing Facility /Physical Rehabilitation Benefit Program (subject to NYC Healthline pre-authorization) which includes:

A maximum of 90 days coverage for Skilled Nursing Facility Care in an Empire Blue Cross Blue Shield participating facility, including 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine. NYC Healthline will work with the member and his/her physician to approve the appropriate level of care. To be eligible to receive benefits, subscribers must contact NYC Healthline at 1-800-521-9574 prior to admission.

The Combined Skilled Nursing Facility/Physical Rehabilitation Benefit allows coverage for up to 90 days per calendar year. Inpatient hospital stays primarily for the purpose of physical therapy, physical medicine, physical rehabilitation, or a combination of these services are counted toward the skilled nursing facility benefit.

Cardiac Rehabilitation Benefit

Cardiac rehabilitation through Empire Blue Cross Blue Shield's participating network facilities is available for select cardiac conditions. This benefit provides up to a maximum 12 weeks rehabilitation or 36, visits subject to prior approval. To be eligible to receive benefits, subscribers must contact NYC Healthline at 1-800-521-9574. Upon approval, NYC Healthline will provide the necessary referral to an Empire Blue Cross Blue Shield's participating Cardiac Rehabilitation Facility.

Over

Emergency Room Physician Coverage

Emergency physician services (non-specialists) rendered in the emergency room of a hospital will be covered by Empire Blue Cross Blue Shield, provided the emergency room treatment is payable by Empire Blue Cross Blue Shield.

Services performed by consulting specialists/private physicians are not considered covered under this benefit. Services for these specialists/private physicians will be covered by GHI, subject to current plan deductibles and/or co-payments.

Please note that emergency room visits remain subject to the $25 co-payment. This $25 co-payment is waived if the emergency room care results in an admission related to the care at the same hospital on the same day.

GHI Comprehensive Benefit Plan (CBP) Medical Benefits

Effective April 1, 1999

GHI-CBP Participating Provider Maternity Fee Schedule Enhancement

The allowance paid to GHI participating providers for vaginal and cesarean deliveries has been increased. This allows GHI to maintain as well as expand its panel of OB/GYN providers.

Catastrophic Deductible Reduction

The catastrophic deductible has been reduced from $3,000 to $1,500 per person per calendar year. Once a member has incurred $1,500 in non-participating provider out-of-pocket expenses, GHI's catastrophic benefit will reimburse a member at 100% of the allowed charge.

Annual Lifetime Plan Maxima

The $200,000 annual maximum per person has been eliminated and the lifetime maximum has been increased to $2 million per person. The Private Duty Nursing annual maxima will remain unchanged.

Effective July 1, 1999

Laboratory and X-ray Copayments

GHI participating provider lab and X-ray services $10 co-payments will be limited to one $10 co-payment for each physician's office visit per day. Members are still responsible for the $10 office visit co-payment when visiting a participating provider.

We feel the significant enhancements made throughout the past several months provide City of New York employees and non-Medicare eligible retirees with important additional benefits. We are delighted to be able to provide continued improvements to your benefits plan while reducing your out-of-pocket expenses. We look forward to continuing to serve you and your family's health benefits needs.

Sincerely,

Steven Kessler
Senior Vice President, GHI

Kevin M. O'Neill
Vice President, Empire Blue Cross

GHI

www.ghi.com

February 8, 2001

Dear City of New York Employee and Non-Medicare Eligible Retiree:

The City of New York Office of Labor Relations and the City's Unions, represented by the Municipal Labor Committee, are once again pleased to announce enhancements to the GHI Comprehensive Benefit Plan (CBP). These benefit enhancements provide additional value to New York City Employees and their covered dependents. These benefit enhancements are specific to only outpatient mental health visits.

Enhanced In-Network Benefit
GHI/BMP In-Network Outpatient Mental Health Visits – Effective January 1, 2001

Outpatient mental health visits rendered by a GHI Behavioral Management Program (GHI/BMP) participating provider under the GHI/BMP Basic program, will be increased from 30 visits per person, per calendar year to an unlimited number of visits per person, per calendar year. Each visit will continue to be subject to medical necessity, precertification under GHI/BMP and a $10 office co-payment. This enhancement to the program eliminates the need to utilize the Optional Rider benefit for additional in-network visits.

Enhanced GHI Optional Rider Benefit
GHI Out-of-Network Outpatient Mental Health Visits – Effective March 1, 2001

For those employees and non-Medicare eligible retirees who purchase the Optional Rider, the GHI Optional Rider benefit will no longer have a lifetime maximum of 60 visits per person for outpatient mental health care rendered by a non-participating provider. The GHI Optional Rider annual limit of 30 visits will continue and will be subject to a $100 deductible per person, per calendar year. Reimbursement for these services will be 50% of the network allowance. This benefit is not subject to precertification.

We would like to remind you that confidential services are available through the City and Union network of Employee Assistance Programs (see Q&A for EAPs list). These programs offer assessment, referral and treatment resources for employees and covered dependents.

Please contact GHI/BMP at 1-800-NYC-City or your Employee Assistance Program to access your behavioral benefits.

To assist you in understanding these benefit changes, enclosed is a list of Questions & Answers. GHI values your membership in the GHI Behavioral Management Program and we look forward to continuing to provide health insurance protection to you and your covered dependents.

Sincerely,

Marilyn DeQuatro
Senior Vice President

GHI
www.ghi.com

EMPIRE BLUECROSS BLUESHIELD

March 1999

Dear City of New York Employee or Non-Medicare Eligible Retiree:

We are pleased to announce a number of significant improvements to your GHI Comprehensive Benefits Plan (CBP) and Empire Blue Cross Blue Shield hospital plan. Through the joint efforts of the City of New York Office of Labor Relations and the City's unions, represented by the Municipal Labor Committee, you and your eligible dependents will enjoy the following program enhancements:

Hospitalization Benefits
(Empire Blue Cross Blue Shield)

365 Day Coverage

- Hospitalization coverage has been increased under the Basic program to a full 365 days of protection. Previously, Empire Blue Cross Blue Shield provided 75 days coverage under the Basic program with an extension to 365 days available with the purchase of the Optional Rider. City of New York active employees and non-Medicare retirees, who presently have the Optional Rider, will notice a reduced contribution level in their wage or pension checks to reflect this savings. This enhancement is effective March 1, 1999.

Medical Benefits
(GHI)

Higher Non-Participating Provider Schedule Reimbursements:

- Optional Rider enrollees will enjoy higher out-of-network reimbursements. The reimbursement under the Enhanced Non-Participating Provider Schedule will increase, on average, an additional 8%. Further, while the benefits provided by the Enhanced Non-Participating Provider Schedule Rider have increased, your payroll or pension contribution for the Optional Rider will not increase. This enhancement is retroactive to January 1, 1999.

Lower Contributions for the Optional Rider:

- Optional Rider enrollees will also realize a reduced contribution level in their wage or pension checks for the GHI Medical and Behavioral Management Program Full-Time Dependent Student portion of the Rider. This enhancement is effective March 1, 1999.

Enhanced Chemotherapy Coverage:

- Chemotherapy benefits have been expanded under the basic GHI-CBP program to cover all related medications, including adjunctive therapies and anti-nauseants. This enhancement to the current chemotherapy basic plan benefit now covers cancer- related chemotherapy drugs in full, when you use a participating retail or mail-order pharmacy. No copayment will be required. This benefit is effective March 1, 1999. Please refer to the enclosed instructions for accessing this benefit.

Over

Asthma Medication Coverage:

- All asthma medications will now be covered under the basic GHI-CBP program. These medications will be covered in full when you use a participating retail or mail-order pharmacy. No copayment will be required. This benefit is effective March 1, 1999. Please refer to the enclosed instructions for accessing this benefit.

Disease State Management Programs for Asthma and Diabetes:

- GHI is introducing Disease State Management Programs for Asthma and Diabetes. Both programs provide free education to members to assist them in managing these conditions. Further details outlining these programs will be forthcoming.

The Women's Health and Cancer Rights Act of 1998 Provides the Following Benefits:

Hospitalization Benefits (Empire Blue Cross Blue Shield)

- Full coverage for the length of a hospital stay for covered persons who have undergone lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer. The length of the hospital stay is left completely in the discretion of the attending physician, in consultation with the patient. The insurer must cover as many days as the attending physician determines are medically appropriate.

Medical Benefits (GHI)

- GHI will provide coverage in a manner determined in consultation between the attending physician and the patient for:
  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

  In addition, New York State law provides coverage for Cancer diagnosis second opinions for eligible members, whether or not the diagnosis is positive. Eligible members may visit any appropriate specialist for the second opinion.

  GHI participating providers have agreed to accept GHI's allowances as payment in full, less applicable copayments, for these covered in-network services. Should you select a non-participating provider, you must pay them directly. Reimbursement for covered services will be made directly to you according to the City of New York Non-Participating Provider Schedule. The benefits for these services will have the same deductibles and limitations applicable to your existing coverage.

We feel these significant enhancements provide City of New York employees and non-Medicare eligible retirees with important additional benefits. We are delighted to be able to provide these key improvements to your benefits plan while reducing your out-of-pocket expenses. We look forward to continuing to serve you and your family's health benefits needs.

Sincerely,

Steven Kessler
Senior Vice President

Kevin M. O'Neill
Vice President

GHI

www.ghi.com

August 28, 2000

Dear City of New York Employee and Non-Medicare Eligible Retiree:

Keeping our commitment to offer health insurance benefits that satisfy the needs of New York City employees and their covered dependents, the City of New York Office of Labor Relations and the City's Unions represented by the Municipal Labor Committee, are pleased to announce the following benefit enhancements for the GHI Comprehensive Benefits Plan (CBP):

New

Annual Physical Exams – Effective – September 1, 2000

For non-Medicare eligible employees and their eligible dependents age 45 and older, GHI CBP will provide coverage for one annual physical examination (based on a calendar year). This benefit will only be covered when services are rendered by a GHI CBP participating provider. A $10 office visit copay will apply. There will be no additional copay for lab and diagnostic radiological services when completed in the physician's office that performs the physical exam. If lab or radiological studies are performed outside the physician's office, these services are subject to the $10 copay that is currently in effect for lab and diagnostic X-Rays. This represents a completely new benefit that will contribute to safeguarding your health through preventive measures.

New

Vaccinations for Influenza and Pneumonia – Effective – September 1, 2000

The cost of the immunizing agents relative to adult vaccinations for influenza and pneumonia will be covered in full. The $10 copay for the office visit will apply. This benefit will only be covered when services are rendered by a GHI CBP participating provider. This benefit is new to the GHI CBP program.

Enhanced

Increased Visit Maximum for Allergy and Physiotherapy – Effective – August 1, 2000

The annual visit maximum has been increased from 16 to 30 visits for Allergy Desensitization and from 8 to 16 visits for Physiotherapy. A provider can request additional visits based on submission of medical documentation for GHI's review and approval.

Process Regarding Grievances, Appeals & External Appeals

In accordance with New York State requirements regarding the filing of grievances and internal/external appeals, enclosed is a rider that amends your GHI CBP Certificate of Insurance. Please review this rider and keep it with your Certificate, as it details your rights in the event you or your provider are questioning GHI's decision pertaining to a claim.

GHI appreciates your participation, and we look forward to continuing to provide you and your dependents with quality health insurance coverage.

Sincerely,

Marilyn DeQuatro
Vice President

Empire BLUECROSS BLUESHIELD

GHI

March 26, 2004

Hospital and Medical Benefit Changes Effective April 1, 2004

Dear City of New York Employee or Retiree:

As a result of negotiations between the City of New York Office of Labor Relations and the Unions, represented by the Municipal Labor Committee, the following benefit changes will become effective on April 1, 2004 for the Empire BlueCross BlueShield and GHI Comprehensive Benefits Plan (CBP) and Senior Care Program. Please read this notification carefully and keep it with your important papers.

CBP Program for Employees and Non Medicare-Eligible Retirees

Hospital Benefits (Empire BlueCross BlueShield)

- The hospital inpatient deductible will change to $300 per admission, with a maximum of $750 per person, per calendar year.
- The hospital emergency room copayment will change to $50 per visit (please note this copayment is waived if you are admitted to the hospital).

Medical Benefits (GHI)

- GHI participating medical providers/practitioners and participating mental health care providers will require a $15 copayment per visit. These include practices such as Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, and providers such as Allergists, Cardiologists, Chiropractors and Gastroenterologists (a full list appears on www.ghi.com).
- GHI participating Surgeons, all Surgical Subspecialties, and Dermatologists will require a $20 copayment per visit. These include providers who practice: Cardiothoracic and Thoracic Surgery; Colon and Rectal Surgery; General Surgery; Neurological Surgery; Ophthalmology; Oral Surgery; Orthopaedic and Hand Surgery; Otolaryngology; Plastic Surgery; Podiatry and Podiatric Surgery; Traumatic Surgery; Urology; Vascular and Veno Surgery.
- GHI participating laboratory and radiology providers will require a $15 copayment per visit. There is a maximum of one copayment per date of service per provider.
- The non-participating provider deductible will change to $200 per individual, per calendar year. Please note that the family deductible will remain unchanged at $500 per calendar year.
- A 25% coinsurance will apply to non-mandated In-Vitro Fertilization services (a list of these services appears on www.ghi.com). The coinsurance applies to services rendered by GHI participating and non-participating providers. Additionally, services rendered by non-participating providers are subject to the non-participating provider deductible.

(See reverse side)

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Senior Care Program for Medicare-Eligible Retirees

Hospital Benefits (Empire BlueCross BlueShield)

- The hospital inpatient deductible will change to $300 per admission, with a maximum of $750 per person, per calendar year.

Medical Benefits (GHI)

- After you have satisfied the Medicare Part B deductible (currently $100), you will be responsible for an additional $50 of covered Senior Care services per individual, per calendar year. GHI then pays the Medicare Part B coinsurance (that is, 20% of Medicare Allowed Charges) for covered services for that calendar year.

  Please note that the separate $25 calendar year deductible for private duty nursing, ambulance, and durable medical equipment will remain unchanged.

Enclosed Identification Cards Reflect Changes

Enclosed are your new GHI medical and Empire BlueCross BlueShield hospital identification cards. **Please replace your current identification cards with the enclosed cards and use the enclosed cards starting April 1, 2004.**

If you have any questions regarding these changes, you may contact:

Empire BlueCross BlueShield: (800) 433-9592 or www.empireblue.com

GHI: (212) 501- 4444 or www.ghi.com

Empire BlueCross BlueShield and GHI are proud to serve City employees and retirees and look forward to continuing to meet the health benefits needs of you and your family.

Sincerely,

Elizabeth McManus
Vice President
Empire BlueCross BlueShield
Operations

Sincerely,

Marilyn DeQuatro
Senior Vice President
GHI Customer Service Division

Enclosure

GHI

Prescription Drug Program Changes Effective September 1, 2004

August 6, 2004

Dear City of New York Employee/Retiree:

This is to inform you of important changes to your prescription drug benefits provided by GHI and managed by Express-Scripts, Inc. (ESI). The following changes will take effect on **September 1, 2004**.

Retail Pharmacy Program:

Each new prescription or refill for up to a 30-day supply filled at a Retail Pharmacy will be subject to the following out-of-pocket costs:

- **Generic drugs** - 20% coinsurance with a minimum charge of $5 or the actual cost of the prescription if it is less than $5
- **Brand-Name Formulary drugs** - 40% coinsurance with a minimum charge of $25 or the actual cost of the prescription if it is less than $25
- **Brand-Name Non-Formulary drugs** - 50% coinsurance with a minimum charge of $40 or the actual cost of the prescription if it is less than $40.

If you choose a formulary or non-formulary brand-name medication that has a generic equivalent, you will be responsible to pay the difference between the cost of the brand-name medication and the generic medication, plus the generic coinsurance. Coinsurance will vary based on the cost of the medication. Your retail pharmacist will calculate the coinsurance amount at the time your prescription is filled.

Mandatory Mail-Service Program:

Prescriptions for up to a 60-day supply filled through the ESI Mail-Service Program will be subject to the following **out-of-pocket costs:**

- **Generic drugs** - $10 copayment
- **Brand-Name Formulary drugs** that are included on the 2004 GHI Formulary - $40 copayment
- **Brand-Name Non-Formulary drugs** that are not included on the 2004 GHI Formulary - $60 copayment.

As a reminder, you **MUST** use the ESI Mail-Service Program for maintenance medications. Maintenance medications (those taken regularly over an extended period of time) **will not be** filled at a retail pharmacy after two (2) fills. If you are currently taking a maintenance medication and have filled it twice at a retail pharmacy, you **MUST** then send it to the ESI Mail-Service Pharmacy. **Please note that if you pay for your prescription at a retail pharmacy after two fills, you will not be reimbursed for the cost of the medication.**

Brand-Name Drugs Requiring Prior Authorization

Effective September 1, 2004, a Prior Authorization Process will be required for certain brand-name medications. These medications require proof of medical necessity and a diagnosis from your physician in order for the prescription to be covered. The following medications currently require prior authorization:

- Nexium
- Prevacid
- Prilosec

If you are currently prescribed any of these medications your doctor must call the ESI Prior Authorization Department at 1-800-417-8164 or fax requests to 1-800-357-9577. If your diagnosis meets approved criteria for that medication and is within the scope of the coverage of the plan, a prior authorization will be set up so your prescription can be filled. If the request is approved, the drug will be covered at the non-formulary brand-name drug cost level.

Step-Therapy Prescription Program

Select drugs on your plan now require a "Step-Therapy Program" that encourages the use of the best medication for your condition. The first steps in this process are well-established treatments known to be safe and effective. Known as first-line therapy, this treatment is the preferred therapy for most people. First-line medications include:

diclofenac sodium (IR and ER)	ibuprofen	naproxen
diclofenac potassium	indomethacin	naproxen sodium (IR and ER)
etodolac (IR and ER)	ketoprofen (IR and ER)	oxaprozin
fenoprofen	ketoralac	piroxicam
flurbiprofen	meclofenamate	sulindac
	nabumetone	tolmetin sodium

If the first-line medication does not work or causes problems, second-line medication can be tried. The following "second-line" medications are currently part of the Step-Therapy Program:

- Vioxx
- Bextra
- Celebrex

When a prescription for a second-line medication is processed at your pharmacy, the computer system reviews your recent prescription history. If a prescription for a first-line drug was previously filled, the second-line medication will be dispensed. If the system does not find a prescription for a first-line drug, the second-line prescription will not be covered. The pharmacist will be alerted that the medication is not covered and can suggest covered first-line alternatives to your physician.

If your physician needs to request an exception, he/she must contact the ESI Prior Authorization Department at (800) 417-8164. If the second-line medication is covered, you will pay a higher cost than for a first-line drug.

Over-the-Counter Equivalent Program

Prescription medications that have an Over-the-Counter (OTC) equivalent will not be covered under the prescription drug program. An example of one such drug is Benzoyl Peroxide - a medication used for the treatment of acne. Benzoyl Peroxide 5% gel is available both by prescription and OTC - which means it will no longer be covered under the prescription drug program.

Convenient Online Access to Important Information:

Visit ESI online at www.express-scripts.com. All you need is your subscriber number to register. Once you register you have easy, around-the-clock Internet access, which will allow you to do the following:

- Order mail-service prescription refills
- Check the status of mail-service prescription orders
- Locate and obtain directions to any of the 56,000 participating retail pharmacies
- Order mail-service envelopes and retail-service claim forms.

If you need further information about the prescription drug benefits changes, please call the ESI Customer Service Center at 1-877-534-3682, 24 hours a day, seven days a week, or visit ESI's Web site at www.express-scripts.com. You can also visit GHI's Web site at www.ghi.com for information regarding your health care benefits coverage.

Sincerely,

Marilyn DeQuatro

Marilyn DeQuatro
Senior Vice President
Customer Service Division

Empire BLUECROSS BLUESHIELD

GHI

March 27, 2004

Hospital and Medical Benefit Changes Effective April 1, 2004

Dear City of New York Medicare-Eligible Retiree:

The following benefit changes will become effective on April 1, 2004 for the Empire BlueCross BlueShield and GHI Senior Care Program. Please read this notification carefully and file it with your important papers.

Senior Care Program for Medicare-Eligible Retirees

Hospital Benefits (Empire BlueCross BlueShield)

- The hospital inpatient deductible will change to $300 per admission, with a maximum of $750 per person, per calendar year.

Medical Benefits (GHI)

- After you have satisfied the Medicare Part B deductible (currently $100), you will be responsible for an additional $50 of covered Senior Care services per individual, per calendar year. GHI then pays the Medicare Part B coinsurance (that is, 20% of Medicare Allowed Charges) for covered services for that calendar year.

  Please note that the separate $25 calendar year deductible for private duty nursing, ambulance, and durable medical equipment will remain unchanged.

If you have any questions regarding these changes, you may contact:

Empire BlueCross BlueShield: (800) 433-9592 or www.empireblue.com

GHI: (212) 501-4444 or www.ghi.com

Empire BlueCross BlueShield and GHI are proud to serve City employees and retirees and look forward to continuing to meet your health benefits needs in the future.

Sincerely,

Elizabeth McManus
Vice President
Empire BlueCross BlueShield
Operations

Sincerely,

Marilyn DeQuatro
Senior Vice President
GHI Customer Service Division

7563 25M 3/06

June 27, 2007

IMPORTANT NOTICE
CONCERNING YOUR CITY OF NEW YORK HEALTH BENEFITS

Dear Non-Medicare Eligible GHI Subscriber:

Effective July 1, 2007, hospital and medical benefits for certain mental health conditions will be enhanced under the GHI CBP/Empire Blue Cross Blue Shield plan. This benefit enhancement is being provided in conformity with recent New York State legislation called "Timothy's Law." Please note: your benefits for substance abuse/chemical dependency treatment are not affected by this change.

Timothy's Law requires that health insurance benefit programs operating under the insurance laws of New York State provide benefits for biologically based mental health conditions and for severe emotional disturbances in children on the same basis as benefits are provided under the plan for all covered medical conditions.

A biologically based mental health condition is defined as: A mental, nervous or emotional condition that is caused by a biological disorder of the brain resulting in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. The following eight conditions are specifically mentioned in the legislation: (1) Schizophrenia/Psychotic disorders, (2) Major depression, (3) Bi-polar disorder, (4) Delusional disorders, (5) Panic disorder, (6) Obsessive compulsive disorder, (7) Bulimia, (8) Anorexia.

The following diagnoses will also be covered under the expanded scope of conditions for children up to age 18 with severe emotional disturbances:

- Attention deficit disorder
- Disruptive behavior disorders
- Pervasive development disorders

In order for services to be considered as treatment of a severe emotional disturbance, and to be covered, these diagnoses must have one or more of the following conditions present:

- Serious suicidal symptoms or self-destructive behavior
- Significant psychotic symptoms – listed as hallucinations, delusions, or bizarre behavior
- Emotional disturbances that put the child at risk or cause injury to others or property
- Emotional disturbances that place the child at substantial risk for removal from the household.

The table below illustrates plan benefits that will be available for treatment of biologically based conditions and severe emotional disturbances in children vs. plan benefits for non-biologically based conditions.

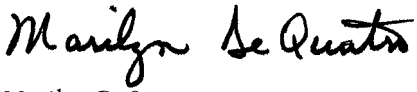
	Biologically Based	**Non-Biologically Based**
Inpatient Hospital Mental Health	Par and Non-Par Providers	Par and Non-Par Providers
Inpatient Days	365 **This is a change in benefit (previously limited to 30 days)**	30 **No change in benefit**
Deductible	$300 per adm/$750 max per calendar year **This is a change in benefit (previously no deductible)**	
Coinsurance	None	Par: None Non-Par: 50% of par allowance up to $4,000, then 100% of par allowance. **No change in benefit**
Partial Hospital or Day Treatment	**Par and Non-Par:** Covered – charges to inpatient days shown above – not subject to deductible. **This is a change in benefit – (previously limited to 30 days)**	**Par:** Covered – charged to inpatient days shown above – not subject to deductible. **No change in benefit** **Non-Par:** 50% of par allowance up to $4,000, then 100% of par allowance. **No change in benefit**
Outpatient Mental Health	**Par:** Unlimited visits subject to a $15 copay per visit. **No change in benefit for using par providers** **Non-Par:** Unlimited visits subject to $200/$500 deductible, 100% coinsurance based on par schedule of allowances; $2 million lifetime maximum. **Change in benefit for using non-par providers (previously subject to $100 deductible and 50% coinsurance)**	**Par:** Unlimited visits subject to a $15 copay per visit. **Non-Par:** Subject to a $100 annual deductible and 50% coinsurance up to 30 visits per calendar year. **No change in benefit**

Mental health benefits continue to be subject to precertification. If you use a GHI/BMP participating facility, the facility will be responsible for precertifying care. If you use a non-participating facility, you must precertify care by calling GHI/BMP at 1-800-692-2489. Failure on your part to precertify care provided by a non-participating facility will result in a penalty of $500 per admission, not to exceed 50% of the benefit that would have been reimbursed if services were precertified. Services rendered by GHI/BMP participating outpatient mental health providers are subject to precertification with the responsibility for precertifying resting with the participating provider. Services rendered by non-participating outpatient mental health providers are also subject to precertification with responsibility for precertifying resting with the patient.

If you have any questions concerning this change in benefits, please call GHI/BMP at 1-800-692-2489.

Please visit GHI.com to review a list of helpful Questions and Answers about Timothy's Law. If you have any other questions, call GHI at 1-800-624-2414.

Sincerely,



Marilyn DeQuatro
Senior Vice President
Customer Service Division

Important Notice About Prescription Drug Benefits For Non-Medicare Eligible Employees/Retirees and Their Dependents

Please be advised that **effective July 1, 2001 the following drugs will no longer be covered** through your prescription benefits with GHI:

- Chemotherapy and Related Drugs
- Drugs to Treat Asthma
- Psychotropic Medications
- Injectable Medications

National Prescription Administrators, Inc. (NPA) and its mail service facility, CFI, Inc. will cover these drugs after 7/1/01.

For Retail Pharmacy Information, **Call NPA 1-800-467-2006**
For Mail Service Information, **Call CFI 1-800-628-0717**

GHI

441 Ninth Avenue New York, NY 10001

www.ghi.com

Your GHI Prescription Drug Coverage

Express Scripts, Inc. (ESI) administers the retail and mail-service pharmacy benefits for City of New York members who receive their prescription drug coverage through GHI under the Optional Rider benefit described in the Certificate of Insurance. ESI manages the prescription benefits needs for one out of every six people in the United States and processes more than 270 million prescriptions annually.

As a participant in the ESI program, you can choose the fulfillment option that best suits your needs:

- **Retail Pharmacy Service**

  To obtain retail pharmacy benefits, juSt present your GHI 10 card at anyone of the more than 56,000 participating ESI pharmacies nationwide. Most major drugstores are included in this network. Please be sure to call your regular pharmacy and confirm whether they participate in this program.

- **Mail-Service Pharmacy**

  In addition to cost savings, the Express Scripts Mail Service program offers you the convenience of home or office delivery, patient education materials, and toll-free access to Customer Service Associates and registered pharmacists. You can submit your mail-service pharmacy prescription by mail, phone, or through the Internet

- **Online service at the ESI Web Site www.express-scripts.com.**
  Another convenient option is to submit your prescriptions online at www.express-scripts.com. Prescriptions submitted online will be mailed to you at the address you specify.

For Additional Information

You can get answers to questions regarding your prescription drug benefits, 24 hours a day, seven days a week with your touch-tone telephone or personal computer. Contact ESI member services at 1- 877-534-3682, or visit ESI's Web site at www.express-scripts.com.

GHI

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www.ghi.com

Women's Health and Cancer Rights Act

GHI is required to inform you that The Women's Health and Cancer Rights Act of 1998 stipulates that if your GHI policy provides mastectomy coverage, GHI will also provide coverage for breast reconstruction surgery, as determined by the physician and agreed upon the patient as follows:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The benefits under this Act will have the same copayments, deductibles and/or co-insurance limitations applicable to your existing coverage.

If you have any questions regarding your GHI benefits, please call GHI Customer Service at (212) 501-4444.

441 Ninth Avenue New York, NY 10001

www.ghi.com

PRESCRIPTION DRUG BENEFIT

Important Information About Your Prescription Drug Benefit for City of New York Employees and Non-Medicare Eligible Retirees

Changes Effective October 1, 2006

September 2006

Dear City of New York Employee and Non-Medicare Eligible Retiree:

This booklet outlines important changes **effective October 1, 2006**, that will occur to your Prescription Drug Benefit, which is provided by GHI and Express Scripts Inc. (ESI).

If you need further information about the prescription drug benefit changes, please call the **ESI Customer Service Center at (877) 534-3682**, 24 hours a day, seven days a week, or visit ESI's Web site at www.express-scripts.com. You can also visit GHI's Web site at www.ghi.com for information regarding your prescription drug benefit coverage.

Sincerely,

Marilyn DeQuatro
Senior Vice President
Group Health Incorporated

PRESCRIPTION DRUG BENEFIT CHANGES

Diabetes Coverage (Available in Base Plan) — Copayment Change

Generic diabetes medication copayments will remain $5.00.

Brand-name diabetes medication copayments will increase to $15.00.

The diabetes medications Symlin and Byetta will be part of the Step-Therapy program. A description of the Step-Therapy program follows.

Prescription Drug Rider — Clinical Management Programs

The clinical guideline programs that are being implemented are: **Prior Authorization and Step Therapy,** as described below.

A. Prior Authorization

Prior authorization is a process in which some medications must be authorized before they can be covered under the program. These medications require that the prescribing physician provide proof of medical necessity and diagnosis. Individuals currently taking drugs that are affected by this change may continue to take them. **The change is for new users of the drugs.** This prior authorization process will be required for the following medications beginning October 1, 2006:

Actiq/ fentanyl	Regranex/ becaplermin
Botox, Myobloc/ botulinum toxin	Revatio/ sildenafil
Diflucan/ fluconazole	Sporanox/ itraconazole
Lamisil/ terbinafine	Tazorac/ tazarotene
Lidoderm/ lidocaine patch	Retin-A/ tretinoin
Novantrone/ mitoxantrone	Sutent/ sunitinib malate
Nexavar/ sorafenib tosylate	Xeloda/ capecitabine
Penlac/ ciclopirox solution	Zyvox/ linezolid
Provigil/ modafinil	

In the future, if you are prescribed any of the drugs listed under **Prior Authorization,** your doctor should call the dedicated **ESI Prior Authorization Line at (866) 467-8635.** If your doctor's diagnosis meets approved guidelines for that drug and is within the scope of the coverage of the plan, a prior authorization will be set up for your prescription to be covered.

B. Step-Therapy Program

Certain drugs on your plan will now require Step Therapy. Individuals currently taking drugs that are affected by this change may continue to take them. **The change is for new users of the drugs**.

Step Therapy requires the use of one or more generic or first-line drugs before a second-line drug is approved. The drugs used as the "first step" are well-established treatments. Known as first-line therapy, these drugs are the preferred therapy over second-line therapies, in most cases. First-line drugs may be filled without calling ESI. If the first-line drug is not effective for you, second-line drugs can be prescribed. To do this, your doctor must call the dedicated **ESI Prior Authorization Line at (866) 467-8635.** If your doctor's assessment meets approved guidelines for that drug and is within the scope of the coverage of the plan, a prior authorization will be set up so your prescription can be filled.

In addition to Symlin and Byetta as previously mentioned, the following second-line drugs are part of the Step-Therapy program.

Anti-inflammatory	Acid Reflux	Asthma or Allergy	Topical Medication	Anti-depressants	
First line Drugs					
Generic anti-inflammatory drugs: Ibuprofen, naproxen and others	Generic acid reflux drugs: Omperazole	Allegra Clarinex Zyrtec, and a nasal corticosteroid	Generic topical corticosteroid drugs: triamcinolone cream and others	Generic anti-depressant drugs: Fluoxetine Citalopram Paroxetine Sertraline Fluvoxamine	
Second Line Drugs					
Arthrotec	Protonix	Singulair	Elidel	Paxil*	Celexa*
Ponstel	Prevacid	Accolate	Protopic	Paxil CR	Sarafem
Mobic	Prevacid SoluTab	Zyflo		Pexeva	Effexor
Prevacid NapraPAC	Prilosec*			Zoloft*	Effexor XR
	Aciphex			Lexapro	Cymbalta
	Nexium			Prozac*	Wellbutrin XL
	Zegerid			Luvox	

Blood Pressure			Cholesterol	Diabetic Drugs
First Line Drugs				
Generic blood pressure drugs:			Generic cholesterol drugs:	Metformin
Captopril	Quinapril	Captopril/hctz	Lovastatin	Sulfonylureas
Enalapril	Benazepril	Enalapril /hctz	Pravastatin	Insulins
Fosinopril	Quinapril/hctz	Fosinopril/hctz	Simvastatin	
Lisinopril	Benazepril/hctz	Lisinopril/hctz		
Second Line Drugs				
Capoten*	Vaseretic*	Zestoretic*	Mevacor*	Byetta
Vasotec*	Prinzide*	Lotensin HCT*	Lipitor	Symlin
Prinivil*	Accuretic*	Monopril HCT*	Lescol	
Zestril*	Lexxel	Benicar	Altoprev	
Univasc	Lotrel	Hyzaar	Pravachol*	
Lotensin*	Tarka	Diovan HCT	Caduet	
Monopril*	Avapro	Avalide	Advicor	
Accupril*	Cozaar	Atacand HCT	Zocor*	
Aceon	Diovan	Micardis HCT	Crestor	
Altace	Atacand	Teveten HCT	Vytorin	
Mavik	Micardis	Benicar HCT		
Capozide*	Teveten			

*Indicates a generic equivalent is available

55 Water Street, New York, New York 10041-8190 | www.emblemhealth.com

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