



CERTIFICATE OF COVERAGE

MetroPlus Health Plan, Inc. (“MetroPlus”) is pleased to provide this Certificate of Coverage for MetroPlus Gold. This Certificate describes the MetroPlus Gold health benefits provided by MetroPlus, located at 160 Water Street, 3rd Floor, New York, New York 10038. This Certificate is provided to each Employee enrolled in MetroPlus Gold through a Group Contract. This Certificate is evidence of the Member’s coverage under the Group Contract. Please note that this is not a contract between the Member and MetroPlus. The Member should keep this document with other important papers so that it is available for the Member’s future reference.

As a Member of MetroPlus Gold, you accept this Certificate and agree to abide by the rules as described herein. As a Member, you are eligible to receive Medically Necessary Covered Benefits described in this Certificate in exchange for the Premium paid to MetroPlus. All health care services must be provided by the Member’s Primary Care Provider, or arranged and authorized in advance by the Member’s Primary Care Provider and MetroPlus, except for Emergency Services described in Part III.B of this Certificate.

MetroPlus, a subsidiary of the New York City Health and Hospitals Corporation, is a health maintenance organization.

Please take time to look over this Certificate. If you have any questions, please call MetroPlus Customer Services at 877-475-3795 or TTY 800-881-2812 from Monday to Saturday 8 am to 8 pm. After business hours, call the MetroPlus After Hours Service Line at 800-442-2560. It is our goal to help you understand your health benefits. We look forward to serving you.

METROPLUS HEALTH PLAN, INC.

A handwritten signature in black ink on a light gray background, reading 'Arnold Saperstein MD'.

Arnold Saperstein MD
President & CEO

MetroPlus Gold Certificate 2010

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Part I – Definitions

- A. **Calendar Year** means the twelve (12) month period beginning January 1 and ending December 31.
- B. **Certificate** means this document and any amendments, which explain the Covered Benefits and other terms of the Member's MetroPlus coverage.
- C. **Co-payment** (or Co-pay) means a fixed dollar amount of Covered Expenses paid by the Member directly to the health care provider at the time services or items are received. Co-payments are described on the Explanation of Co-payments included with this Certificate. Co-payments may be changed by MetroPlus from time to time.
- D. **Cosmetic** means a service or item the purpose of which is to alter one's appearance without affecting the body's function. The determination of whether a service or item is Cosmetic is subject to Medical Necessity and may be appealed to an External Appeal Agent pursuant to an external review performed in accordance with Article 49 of the New York Public Health Law. For further information on external appeals, consult the MetroPlus Gold Member Handbook.
- E. **Covered Benefits** or **Covered Services** means the health care services and items for which coverage is provided under this Certificate.
- F. **Covered Expenses** means the expenses for Covered Benefits incurred by a Member that will be reimbursed by MetroPlus under the terms of this Certificate. Covered Expenses include only those charges for health care services and items which are less than or equal to our maximum allowable fees in effect at the time the service is rendered or the item is purchased.
- G. **Custodial Care** means help in transferring, eating, dressing, bathing, toileting and other such related activities.
- H. **Dependent** means anyone in the Employee's family who meets the eligibility requirements described in Part II.A.2 of this Certificate and who has been enrolled by the Employee.
- I. **Durable Medical Equipment** (DME) means devices and equipment (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) ordered by a Plan Provider for the treatment of a specific medical condition that:
1. Can withstand repeated use for a protracted period of time, and
 2. Are primarily and usually used for a medical purpose, and
 3. Are generally not useful to a person in the absence of illness or injury, and
 4. Are usually not fitted, designed or fashioned for a particular person's use
- Durable Medical Equipment must meet the criteria specified in Part III.J.2 in order to be a Covered Benefit.
- J. **Emergency Condition** means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
1. Placing the health of the person afflicted with such condition, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
 2. Serious impairment to such person's bodily functions;
 3. Serious dysfunction of any bodily organ or part of such person; or
 4. Serious disfigurement of such person.
- K. **Emergency Services** are Medically Necessary services provided in connection with an Emergency Condition.
- L. **Employee** means a person who meets the eligibility requirements in Part II.A.1 of this Certificate. To receive Covered Benefits, the Employee must complete an Enrollment Form and pay, or have paid on his or her behalf, all applicable Premiums. The Employee is the person to whom this Certificate is issued.
- M. **Enrollment Form** means the document provided by the Member and/or the Group, either printed or in any other media, including electronic media, that provides the information required by MetroPlus to enroll the Member and the Member's Dependents under this Certificate.
- N. **Experimental/Investigative** means that the treatment, procedure, drug, device or any hospitalization in connection with same is:
1. Not of proven benefit for the particular diagnosis or treatment of the Member's particular condition; or
 2. Not generally recognized by the medical community as reflected in the published peer-reviewed

medical literature as effective or appropriate for the particular.

- O. **Group** means the employer or other party that has entered into a Group Contract with MetroPlus through which this Certificate is made available to eligible persons. The Group is not an agent of MetroPlus.
- P. **Group Contract** means the agreement between the Group and MetroPlus through which Covered Benefits are provided.
- Q. **Group Open Enrollment Period** means a period of time established by the Group and MetroPlus during which eligible persons who have not previously enrolled with MetroPlus may do so. The Group Open Enrollment Period may change from time to time, but will occur at least once every twelve (12) months.
- R. **Health Professional** means a person who is licensed, certified or otherwise qualified under a state's laws to provide certain Covered Benefits pursuant to such license, certification or other qualification.
- S. **Home Health Agency** means an agency that provides Skilled Services and other therapeutic services in the Member's home when Medically Necessary. The Member must be confined to the Member's home because of the Member's health, and the services must be authorized by the Member's Primary Care Provider and MetroPlus.
- T. **Hospital** means a duly licensed, short term acute care hospital which is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons, and which otherwise meets all requirements of applicable law. A Hospital is not, other than incidentally, a place primarily for the treatment of tuberculosis, a place of rest, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial or rehabilitatory care.
- U. **Maternity Care** includes care required by pregnancy, childbirth, abortions and miscarriages.
- V. **Medically Necessary Care** (Medical Necessity) means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the Member's capacity for normal activity or threaten some significant handicap. Services or supplies that are not provided in the most appropriate setting or level of care are not Medically Necessary.
- W. **Member** means any Employee or enrolled Dependent entitled to Covered Benefits under this Certificate.
- X. **Orthotics** means an orthopedic appliance or apparatus used to support, align, prevent or correct deformities; or to improve the function of movable body parts (i.e., a device to assist a dysfunctional joint).
- Y. **Out-of-Area Services** means Covered Services provided outside of the MetroPlus Service Area. Out-of-Area Services are limited to Emergency Services and services that are arranged and authorized in advance by the Primary Care Provider and MetroPlus.
- Z. **Out-of-Network Services** means those Covered Services provided by a non-Participating Provider. Coverage for Out-of-Network Services is limited to Emergency Services and services that are arranged and authorized in advance by the Primary Care Provider and MetroPlus.
- AA. **Participating Provider** means a Plan Provider, Health Professional, a supplier of health care services or items, or a health care facility that has an agreement with MetroPlus to provide health care services or items to MetroPlus Members.
- BB. **Plan Provider** means a Primary Care Provider or Specialist with whom MetroPlus has an agreement.
- CC. **Premium** means the periodic payment (usually monthly) made to MetroPlus on the Member's behalf that entitles the Member to the benefits in this Certificate.
- DD. **Primary Care Provider, or PCP**, means an internist, family practice physician, pediatrician or nurse practitioner who is chosen by the Member from MetroPlus' list of Plan Providers.
- EE. **Professional Services** mean Covered Services performed by Health Professionals that are Medically Necessary, generally recognized as appropriate care within the Service Area, and in accordance with MetroPlus' policies and procedures.
- FF. **Prosthetics** means devices that replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ or part. Internal prosthetics are implanted into or permanently attached to the body. External prosthetics are readily removable and do not become a permanent part of the body.
- GG. **Referral** means the recommendation of the Member's Primary Care Provider or other Plan Provider for the Member to be evaluated and/or treated by a different physician, specialist or service provider. Most services require a Referral.

- HH. **Riders** mean amendments to this Certificate that change the benefits made available to the Group. Such Riders, when purchased by the Group, will be included with and become a part of this Certificate.
- II. **Service Area** means the counties of New York, Queens, Kings and Bronx in the State of New York.
- JJ. **Skilled Nursing Facility** means a facility that is specially qualified to provide inpatient medical and nursing care. The facility must be recognized and certified as such by Medicare, and fall within the definition of a Skilled Nursing Facility under Title XVIII of the Social Security Act.
- KK. **Skilled Services** mean Skilled Nursing or Skilled Rehabilitation services rendered in a Skilled Nursing Facility, in a Hospital, or by a Home Health Agency in the Member's home at a skilled level of care.
1. Skilled Nursing care means care that can be performed only by, or under the supervision of, licensed nursing personnel on a daily basis. (This may be on an intermittent basis for a member receiving home care).
 2. Skilled Rehabilitation (Physical and Occupational Therapy) means therapy that can be performed only by, or under, the supervision of a professional physical or occupational therapist on a daily basis which leads to a higher level of functioning. (This may be on an intermittent basis for a member receiving home care.)
- LL. **Specialist** means a physician or other Health Professional who provides Covered Services on a referral basis or in the case of an Emergency Condition. All Referrals to Specialists must be made by the Primary Care Provider.
- MM. **Urgent Care Center** means a free-standing facility or an urgent care department within a Hospital that provides care to patients requiring Urgent Services.
- NN. **Urgent Services** are Covered Services for conditions which are not life threatening, but which require prompt treatment to prevent serious deterioration of the Member's health.
- OO. **Young Adult** means an unmarried child who exceeds the age limit for coverage under this group contract whose parent is a Member and who:
1. is under the age of thirty (30);
 2. is not insured by or eligible for coverage through his or her own employer, provided that the employer's policy includes both hospital and medical benefits;
 3. lives, works or resides in the MetroPlus Service Area; and
 4. is not covered by Medicare.

Part II - Eligibility, Enrollment and Effective Date of Coverage

A. Eligibility.

1. *Employee.* To be eligible to enroll as an Employee you must:
 - a. Reside or work in the Service Area; and
 - b. Be a bona fide employee of the Group entitled to participate in the health care benefit program arranged by the Group, or be entitled to coverage under a trust agreement or through membership in an association; and
 - c. Satisfy any probationary or waiting period requirements established by the Group and meet all eligibility requirements of the Group.
2. *Dependents.* To be eligible to enroll as a Dependent the person must:
 - a. Meet all Dependent eligibility requirements established by the Group; and
 - b. Reside with the Employee, except that a child does not need to reside with the Employee; and
 - c. Be the Employee's lawful spouse or qualified domestic partner (as evidenced by a current Certificate of Domestic Partnership issued by the New York City Clerk's Office); or
 - d. *Dependent Children Coverage:*
 - (1) If the Employee selected other than individual coverage, the Employee's children who are under the age of 26 may be covered under this Certificate of Coverage. Coverage lasts until the end of the month in which the child turns 26 years of age. The Employee's children need not be financially dependent upon the Employee for support or claimed as dependents on the Employee's tax return; residents of the Employee's household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Certificate of Coverage. If the Employee's 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 this Certificate of Coverage.
 - (2) Coverage for the Employee's 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 this Certificate of Coverage remains in effect and the child remains in such condition, if the Employee submits proof of the Employee's child's incapacity within 31 days of the Employee's child attaining age 26.
 - e. The following are considered children:
 - (1) Natural children
 - (2) Legally adopted children
 - (3) Children whom the Employee proposes to adopt and who are dependent upon the Employee during the waiting period prior to adoption
 - (4) Newly born infants adopted by the Employee if:
 - (a) The Employee takes physical custody of the infant upon the infant's release from the Hospital and the Employee files a petition pursuant to New York State Domestic Relations Law, Section 115-c, within thirty (30) days of birth, and
 - (b) Provided that no notice of revocation to the adoption has been filed pursuant to New York State Domestic Relations Law, Section 115-b, and
 - (c) Consent to the adoption has not been revoked.

Please note: MetroPlus will not cover the infant's initial Hospital stay when a natural parent has insurance coverage available for the infant's care.
 - (5) Children for whom the Employee is the court appointed legal guardian and who are chiefly dependent upon the Employee for support and maintenance
 - (6) Stepchildren who are dependent upon the Employee for support and maintenance
 - (7) Natural children of the Employee's covered Dependent ("grandchild") if his/her grandchildren are dependent upon the Employee for support and maintenance; the Employee's grandchild may remain covered only while his/her parent is covered as a Dependent
 - (8) Children of domestic partners as long as the domestic partner is covered as a Dependent

Please note: MetroPlus has the right to verify whether a child continues to qualify as a Dependent under this section of the Certificate.

B. Enrollment.

Apart from anything else in this section, the Member will not be eligible to re-enroll in any MetroPlus plan if the Member's coverage has been terminated under Part VI.C.5 of this Certificate.

1. *Group Open Enrollment.* An Employee is entitled to enroll himself/herself and his/her eligible Dependents during Group Open Enrollment Periods. All persons included for coverage must be listed on the Enrollment Form provided. No proof of insurability will be required.
2. *Newly Eligible Employees and Dependents.* Employees may become eligible to enroll at a time that does not fall within the Group Open Enrollment Period. When this occurs, an Employee may enroll himself/herself and his/her eligible Dependents within thirty (30) days of becoming eligible. If someone later becomes eligible as a Dependent, the Employee may enroll that person by completing and submitting a signed Enrollment Form within thirty (30) days of such person becoming eligible (e.g., from the date of birth, adoption, marriage, etc.) to the Group's benefits office. No proof of insurability will be required. However, proof of eligibility may be required.
 - a. A newborn child of the Employee will be covered from the date of birth, if notice is given within 30 days of birth. If notice of birth is not given within 30 days of birth, coverage will be effective from the date that notice is given.
3. *Limitation.* Persons initially or newly eligible for enrollment who do not enroll within thirty (30) days of eligibility may enroll only during the next Group Open Enrollment Period. If any of the following conditions are met, coverage must be applied for within 30 days of termination of any of the following:
 - a. The newly eligible Employee or Dependent was covered under another plan or contract at the time coverage was initially offered.
 - b. Coverage under the other plan or contract was:
 - (1) Provided in accordance with continuation required by federal or state law and was exhausted;
 - (2) Subsequently terminated as a result of loss of eligibility for one or more of the following reasons:
 - (a) Termination of employment;
 - (b) Termination of the other plan or contract;
 - (c) Death of the spouse;
 - (d) Legal separation, divorce or annulment;
 - (e) Reduction in number of hours of employment; or
 - (3) Contract holder contributions toward the payment of premiums for the other plan or contract were terminated.
4. *Notice of Ineligibility.* It is the Employee's responsibility to notify MetroPlus of any changes affecting the Employee's eligibility or the eligibility of the Employee's Dependents within thirty (30) days of the change. This includes, but is not limited to, loss of eligibility due to divorce, death, marriage, employment, loss of full time student status, or age. Failure to notify MetroPlus of ineligibility may constitute fraud and could result in the termination of coverage under this Certificate and in civil and/or criminal legal action against the Employee and/or the Member.

C. Effective Date of Coverage.

After MetroPlus receives the completed Enrollment Form, including selection of a PCP, and the appropriate arrangements for payment of Premium are made, the coverage under this Certificate will begin on the following dates:

1. *Initial Enrollment and Open Enrollment.* Coverage will begin on the date agreed upon by the Group and MetroPlus.
2. *Newly Eligible Employees and their Dependents.* Coverage will begin on the date agreed upon by the Group and MetroPlus.
3. *Newly Eligible Dependents.* Coverage will begin as of the date of the event such as marriage, birth, adoption or guardianship, but only if the Enrollment Form is received within thirty (30) days of the event.

4. *The Effective Date of Coverage* may be changed by agreement of the Group and MetroPlus.

D. Renewal Date.

This Certificate renews July 1 of each year.

Part III - Covered Services and Benefits

General Provisions

1. The Member is eligible to receive the following medical, surgical, diagnostic, therapeutic and preventive services and items generally and customarily provided in the Service Area. As a Member of a health maintenance organization, the Member and the PCP must work together. The PCP has accepted the responsibility to provide, coordinate and arrange the Member's health care services.
2. MetroPlus will not cover any health service or item that is not Medically Necessary, unless specified in this section (Part III). MetroPlus will cover a service or item for which coverage had been denied for lack of Medical Necessity only if required by an External Appeal Agent pursuant to an external review performed in accordance with Article 49 of the New York Public Health Law. Coverage would then be provided only to the extent that such service or item is a Covered Service. For further information on external appeals, please consult the MetroPlus Gold Member Handbook.
3. **Except in an Emergency Condition as described in Part III.B of this Certificate**, the only Covered Benefits are those that are provided by the Member's PCP or referred by the Member's PCP. This is true even if a service is listed as a Covered Benefit.
4. **Except for an Emergency Condition as described in Part III.B of this Certificate**, Out-of-Network Services and/or Out-of-Area Services are not covered. The only exception is for a Covered Service for which it is Medically Necessary that the service be obtained as an Out-of-Network Service and/or Out-of-Area Service and for which prior authorization has been issued.

A. **Doctors and Other Health Professional Services**

The Member must select a PCP who will provide, arrange and coordinate all the Member's health care needs. A female Member may select an OB/GYN as her PCP. Coverage is provided for:

1. *Office Visits.* Services for the prevention, diagnosis and treatment of illness or injury when provided in the medical office of the PCP or an authorized Specialist.
2. *Hospital Services.* Services of the PCP and other authorized Health Professionals for diagnosis, treatment and consultation are provided while the Member is hospitalized for authorized services and/or Emergency Services as described in this Certificate.
3. *Outpatient Services.* Services for the diagnosis and treatment of illness or injury in an outpatient setting by the PCP or other authorized Health Professional. Services include surgery, anesthesia, radiation therapy, chemotherapy, dialysis treatments, respiratory therapy and cardiac rehabilitation therapy.
4. *Physician Home Visits.* Home visits provided by the PCP or authorized Specialist when indicated by the nature of the illness or injury.
5. *Second Surgical Opinion.* A second surgical opinion is covered provided that:
 - a. The Member's PCP or a Plan Provider of an appropriate specialty recommends that surgery be performed;
 - b. The second surgical opinion is provided by a Plan Provider who is an appropriate Specialist; and
 - c. The second surgical opinion is given with respect to a surgical procedure of a non-emergency nature for which Covered Benefits would be provided under this Certificate.
6. *Second Medical Opinion for Cancer Diagnosis and Treatment.* A second medical opinion by an appropriate Specialist in the event of:
 - a. A positive or negative diagnosis of cancer;
 - b. A recurrence of cancer; or
 - c. A recommendation of a course of treatment for cancer.An appropriate Specialist includes, but is not limited to a Specialist affiliated with a specialty care center for the treatment of cancer. Second medical opinions for the treatment of cancer can be obtained from either a Participating or non-Participating Provider.
7. *Allergy Care.* Allergy testing, evaluation, serum and injections when provided by the PCP or an authorized Specialist.
8. *Plastic and Reconstructive Surgery.*
 - a. Plastic and reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part, or when there is a congenital disease or anomaly

- which has caused a functional defect, but only when the surgery is reasonably expected to correct the condition.
- b. **Breast Reconstruction.** Reconstruction of a breast following a mastectomy is covered. Coverage is also provided for surgery and reconstruction of the other breast to produce a symmetrical appearance, in the manner determined by the Plan Provider and the patient to be appropriate. Services must be pre-authorized by and arranged by a Plan Provider.
- 9. **Chiropractic Services.** Only for the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Covered chiropractic care is limited to the treatment of conditions that, in the judgment of a Plan Provider, are subject to significant clinical improvement within a reasonable period of time and for which treatment leads toward resolution of the condition. Maintenance treatment for conditions that does not result in significant clinical improvement or lead toward resolution of the condition is not a Covered Benefit. Chiropractic services must be referred by the Member's PCP.
 - 10. **Injectable drugs.** Injectable drugs administered by a physician who is a Plan Provider are Covered Benefits.
 - 11. **Podiatry Services.** Podiatry services are covered with the exception of routine foot care services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
 - 12. **Smoking Cessation.** Up to six (6) smoking cessation counseling visits are covered.

B. Emergency Care, Urgent Care and Ambulance Services

- 1. **Emergency Care.** Coverage is provided for Emergency Services as defined in Part I.K of this Certificate. **The Member is not required to obtain prior authorization before seeking Emergency Services.** In the event that the Member is faced with a situation that the Member is sure is an Emergency Condition as defined in Part I.J of this Certificate, the Member should go directly to an emergency room. However, in the event that the Member is faced with a situation that the Member is not sure is an Emergency Condition, the Member should contact the PCP for advice and direction prior to receiving Emergency Services. After business hours, call the MetroPlus After Hours Service Line at 800-442-2560.

If the Member seeks Emergency Services and the situation is not an Emergency Condition, coverage will not be provided for those services.

If the Member did not contact the PCP prior to receiving Emergency Services, the Member or a designee should notify the PCP the next business day after receiving care so that the PCP can coordinate any necessary follow-up care.

If the Member is hospitalized for Emergency Services in a Hospital that is a non-Participating Provider or an Out-of-Area Hospital, MetroPlus may require that the Member be transferred to a Hospital or other facility that is a Participating Provider within the Service Area as soon as medically possible.

- 2. **Urgent Care.** Coverage is provided for Urgent Services as defined in Part I.NN of this Certificate if the PCP determines Urgent Care is required but cannot see the patient. The PCP can refer the patient to the nearest participating Urgent Care Center for treatment. These services are covered only if the PCP referred the patient to the Urgent Care Center.

If the Member requires Urgent Care while Out-of-Area, call the MetroPlus After Hours Service Line at 800-442-2560. The Member will be put in direct contact with a provider or be directed to the nearest emergency room.

3. *Prehospital Emergency Medical Services.* Coverage is provided for the prompt evaluation and treatment of an Emergency Condition and/or non-air-borne transportation of a Member to a Hospital when such services are provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NY State Public Health Law, and a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
 - a. Placing the health of the afflicted Member, or in the case of a behavioral condition, placing the health of the Member or others, in serious jeopardy;
 - b. Serious impairment to such Member's bodily functions;
 - c. Serious dysfunction of any bodily organ or part of such Member; or
 - d. Serious disfigurement of such Member.

C. Health Maintenance and Preventive Services

Coverage is provided for the following health maintenance and preventive services:

1. *Periodic health assessments.* Two routine preventive exams each year and any necessary Covered Benefits resulting from these exams and for any acute problem.
2. *Gynecological Exams.* Two (2) routine preventive gynecological examinations each year and any necessary follow-up care resulting from these examinations and for any acute gynecological condition.
3. *Well-Child Visits.* Well child visits through age eighteen (18), according to American Academy of Pediatrics guidelines. No Co-payment or Coinsurance will be required for such well child visits.
4. *Preventive Services.* The following preventive services will be Covered Services when received from Participating Providers:
 - a. Services with an "A" or "B" rating from the United States Preventive Services Task Force;
 - b. Immunizations as recommended by the Advisory Committee on Immunization Practices ("ACIP"), including for a child, all immunizations that are recommended by the American Academy of Pediatrics; and
 - c. Evidence-informed preventive care and screenings that are provided for in the comprehensive guidelines issued by the Health Resources and Services Administration ("HRSA").
5. *Mammography Screening.* Mammography screening is covered under the following conditions:
 - a. On the recommendation of a Plan Provider, a mammogram at any age for Members having a prior history of breast cancer or whose first degree relative has a prior history of breast cancer.
 - b. A single baseline mammogram for Members age thirty-five (35) through thirty-nine (39).
 - c. A mammogram every year for Members age forty (40) and over.
 - d. No more than one (1) routine mammography screening will be covered during a Calendar Year.
6. *Diagnostic Screening for Prostatic Cancer.* Diagnostic screening for prostatic cancer is covered under the following conditions:
 - a. Standard diagnostic testing including a digital rectal examination and a prostate-specific antigen (PSA) test at any age for men having a prior history of prostate cancer; and
 - b. An annual standard diagnostic examination, including a digital rectal examination and a prostate-specific antigen test for men age fifty (50) and over who are asymptomatic and for men age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.
7. *Cervical Cytology Screening.* For women aged eighteen (18) and older, annual cytology screening for cervical cancer and its precursor states. Coverage includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.
8. *Bone Mineral Density Measurements or Tests.* Coverage is provided for bone mineral density measurements or tests, including those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health (NIH) and, if consistent with such criteria, dual-energy x-ray absorptiometry. Coverage shall be provided to Members who qualify under the criteria of the federal Medicare program or the criteria of the NIH, including Members who meet the following criteria:
 - a. The Member has previously been diagnosed with osteoporosis or has a family history of osteoporosis;

- b. The Member has symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis;
 - c. The Member is on a prescribed drug regimen posing a significant risk of osteoporosis; or
 - d. The Member's age, gender, other physiological characteristics and/or lifestyle factors pose a significant risk of osteoporosis.
9. *HIV Primary and Secondary Prevention and Risk-Reduction Services.* Coverage is provided for these services.

D. Home Health Care and Hospice Care

1. *Home Health Services.* Coverage is provided for in-home Skilled Services by Health Professionals only when a stay in a Hospital or Skilled Nursing Facility would otherwise have been required. Coverage must be authorized by the MetroPlus Medical Director or his/her designee. MetroPlus will cover up to forty (40) home care visits per calendar year. Each visit by a Health Professional shall be considered as one home care visit, and four hours of home health aide service shall be considered as one home care visit. Home care shall consist of the following:
 - a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.);
 - b. Part-time or intermittent home health aide services which consist primarily of caring for the Member;
 - c. Physical, occupational or speech therapy if provided by the home health service or agency; and
 - d. Laboratory services and medical supplies, drugs and medications prescribed by a physician and administered by a certified home health agency or licensed home care services agency to the extent such items would have been covered or provided under this Agreement if the Member had been confined to a Hospital or Skilled Nursing Facility.
2. *Hospice Care.* Terminally ill Members are eligible for hospice care. A Member is considered terminally ill if the PCP has certified the Member as having a life expectancy of six (6) months or less. All care must be provided by a certified hospice organization and must be authorized by the MetroPlus Medical Director or his/her designee. Coverage is provided for the following services:
 - a. Inpatient care (in a hospice, Skilled Nursing Facility, or a Hospital) and outpatient care as determined by the Member's PCP and approved by MetroPlus;
 - b. Drugs and medical supplies provided by the Hospital, Skilled Nursing Facility or hospice;
 - c. Up to five (5) visits for bereavement counseling for family members before or after the death of the Member.

E. Hospital Services and Skilled Services

All Hospital services must be authorized by the MetroPlus Medical Director or his/her designee and arranged by the Member's PCP, except as described under Part III.B of this Certificate.

1. *Inpatient Services.* Coverage is provided for the following inpatient services:
 - a. Semi-private room and board, with no limit to number of days.
 - b. Private rooms are covered only when Medically Necessary, authorized by a Plan Provider, and approved by the MetroPlus Medical Director or his/her designee.
 - c. Medical, surgical and nursing services.
 - d. Laboratory, x-ray and other diagnostic services.
 - e. Drugs, medications, biologics and their administration.
 - f. Use of operating and delivery rooms and related facilities.
 - g. Anesthesia and oxygen services.
 - h. Acute medical rehabilitation consisting of physical therapy and other rehabilitation services required as part of an approved Hospital stay, limited to services anticipated to result in significant clinical improvement within a reasonable period of time (not to exceed sixty (60) days).
 - i. Radiation therapy, chemotherapy and dialysis.
 - j. Blood and blood plasma and their administration.

2. *Pre-Admission Testing.* Coverage is provided for tests that must be performed before the Member is admitted to a Hospital for surgery and ordered by a Plan Provider. The tests must meet the following conditions:
 - a. They must be consistent with the diagnosis and treatment of the condition for which surgery is to be performed.
 - b. The Member must have a reservation for the Hospital bed and/or for the operating room before the tests are given.
 - c. The Member must be physically present at the Hospital when the tests are given.
 - d. Surgery must actually take place no more than seven (7) days after the tests are performed.
3. *Outpatient Services.* Coverage for the following services through a Hospital outpatient department is provided when referred (and, in some cases, authorized) by a Plan Provider:
 - a. Radiation therapy, chemotherapy and dialysis,
 - b. Diagnostic tests and procedures,
 - c. Short-term rehabilitation services (not to exceed 20 visits per calendar year) meeting the criteria for Rehabilitation Services in Part III.H,
 - d. Outpatient surgery that is authorized by the MetroPlus Medical Director or his/her designee.
4. *Skilled Services.* Coverage is provided for the following inpatient semi-private Skilled Services and accommodations when authorized by the MetroPlus Medical Director or his/her designee.
 - a. Skilled Services in a Skilled Nursing Facility or in a Hospital are covered for up to thirty (30) days per Member per Calendar Year.
 - b. If the Member remains in a Skilled Nursing Facility or Hospital after discharge is ordered or after the maximum benefit period is reached, the Member will be responsible for all associated costs for the services.
 - c. Care in a Skilled Nursing Facility or Hospital that does not meet the criteria for Skilled Services is considered Custodial Care or domiciliary care. Such care is not a Covered Benefit.
5. *End of Life Care.* For Members diagnosed with advanced cancer, as defined below, coverage is provided for acute care services at an acute care facility licensed pursuant to Article 28 of the NY State Public Health Law specializing in the treatment of terminally ill patients, if the Member's Specialist, in consultation with the medical director of such facility, determines that the Member's care would appropriately be provided by the facility.
 - a. Advanced cancer is defined as a form or degree of cancer from which there is no hope of reversal of the primary disease and fewer than sixty (60) days to live, as certified by the Member's Specialist.
 - b. In the event of any dispute over whether admission to an acute care facility under this section is required, MetroPlus agrees to initiate an appeal and cover any services rendered while an expedited appeal is pending in accordance with Article 49 of the New York Public Health Law.

F. Laboratory and Radiology Services

Coverage is provided for the following services performed in an outpatient setting ordered by a Plan Provider:

1. *Laboratory Services.* Tests provided in a free-standing or Hospital-based laboratory.
2. *Radiology Services.*
 - a. Diagnostic radiological procedures, including, but not limited to, x-ray examinations, mammography, bone density, magnetic resonance imaging (MRI), Computed Tomography (CT or CAT) scans, nuclear medicine and ultrasounds.
3. *Radiation oncology.*
4. *Mammography.* Please see Part III.C.5 for information regarding covered mammograms.

G. Maternity and Family Planning Services

Coverage is provided for the following maternity and family planning services:

1. *Maternity Care.* Coverage is provided for care required by childbirth (including prenatal and postnatal care) and miscarriages. This includes use of Hospital delivery rooms and related facilities; use of newborn nursery and related facilities; Professional Services related to the delivery; and special procedures as determined by the PCP or Plan OB/GYN, such as sonograms and amniocentesis.

Authorization is not required for in-network maternity and newborn admissions. The Member or a designee should notify MetroPlus the next business day after a delivery so that MetroPlus can arrange to pay non-Participating Providers. Coverage for inpatient confinement includes:

- a. The mother and newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section and for at least ninety-six (96) hours after a cesarean section.
 - b. Parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.
 - c. One post-partum home health care visit if the mother is discharged earlier than provided in Part III.G.1.a. The visit may be requested any time within forty-eight (48) hours of the delivery (ninety-six [96] hours in case of cesarean section) and shall be delivered within twenty-four hours after discharge or at the time the mother requests, whichever is later. No Co-payment or Coinsurance will be required for such a maternity home health care visit.
 - d. Up to two medically necessary post-partum home health care visits for high risk infants and mothers. No Co-payment or Coinsurance will be required for such a maternity home health care visit.
2. *Midwifery Services.* Coverage is provided for services by a midwife who is a Participating Provider including the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate. The midwife must be licensed by the State Department of Education.
 3. *Family Planning Services.* Coverage is provided for diagnosis, counseling, abortions and services when authorized by a PCP or OB/GYN.
 4. *Infertility.* Coverage is provided for the diagnosis and treatment of correctable medical conditions that would otherwise be Covered Benefits, when such medical condition results in infertility, as determined in accordance with the standards and guidelines established and adopted by the American Society for Reproductive Medicine. For Members twenty-one (21) to forty-four (44) years inclusive, Covered Benefits include the following diagnostic and treatment procedures:
 - a. Surgical or medical procedures or care provided as part of hospital care that could correct malformation, disease or dysfunction resulting in infertility;
 - b. Services related to the diagnosis and treatment of infertility;
 - c. Tests and procedures for the diagnosis of infertility, including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, pelvic sonogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound.
 - d. Coverage is not provided for services in connection with:
 - (1) In vitro fertilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT);
 - (2) Reversal of elective sterilizations;
 - (3) Sex change procedures;
 - (4) Cloning; or
 - (5) Medical or surgical services or procedures that are deemed Experimental/Investigative in accordance with the standards and guidelines established and adopted by the American College of Obstetrics and Gynecology and the American Society for Reproductive Medicine.

H. Outpatient Rehabilitation Services

1. *Rehabilitation Therapy.* Coverage is provided for outpatient speech therapy, physical therapy and occupational therapy when prescribed by a Plan Provider of an appropriate specialty. Rehabilitation therapy is therapy that is anticipated to result in significant clinical improvement within a reasonable period of time (not to exceed twenty (20) visits per calendar year).
 - a. Maintenance therapy for chronic conditions is not a Covered Benefit.
 - b. Speech therapy and services associated with a learning disability are not covered if such therapy or services are available through the school district according to New York State Public Health Law and/or the Federal Individuals with Disabilities Education Act (IDEA).

2. *Developmental Delay.* Coverage is provided for speech therapy services for children with developmental delay through age three (3) subject to the limitations noted in paragraph 1 above.
3. *Cardiac Rehabilitation.* Coverage is provided for cardiac rehabilitation which involves coordinated interventions designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered on an outpatient basis when prescribed by a Specialist who is a Plan Provider.

I. Mental Health and Substance Abuse Services

1. *Mental Health Services*
 - a. *Inpatient Hospital Mental Health Services.* Coverage is provided for a stay in a semi-private room and related Professional Services, when Medically Necessary, and authorized by the MetroPlus Medical Director or his/her designee, except as described under Part III.B of this Certificate.
 - b. *Outpatient Mental Health Services.* Coverage is provided for Professional Services required for crisis intervention and short-term evaluative services.
2. *Alcohol and Substance Abuse Services.* Coverage is provided for the alcohol and substance abuse services described below.
 - a. *Detoxification.* Includes a stay in a semi-private Hospital room, not to exceed five (5) days per admission, or services at an outpatient facility, and Professional Services relating to detoxification of alcohol or drug abuse when rendered in a Hospital or a facility approved by MetroPlus. Prior authorization by the MetroPlus Medical Director or his/her designee is required for any inpatient hospital detoxification services.
 - b. *Outpatient Alcohol and Substance Abuse Services.* Coverage is provided for Professional Services for outpatient alcohol and substance abuse including diagnostic evaluations to determine the nature and extent of the Member's illness, counseling and active therapy. Up to twenty (20) visits may be used by family members for family therapy related to the Member's alcohol or substance abuse. Coverage is not provided for outpatient services that consist primarily of participation in programs of a social, recreational, or companionship nature.
 - c. *Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Chemical Dependence.* SBIRT is a service provided by emergency departments, hospital outpatient departments and free-standing diagnostic and treatment centers and is intended to identify individuals with or at risk of substance abuse problems, assess the extent of substance use, provide brief intervention or brief treatment and refer to chemical dependence treatment, as appropriate.
 - d. *Other Services.* No coverage is provided for ancillary services resulting from abuse of or addiction to alcohol or drugs. However, determination of the need for those services is covered.
3. *Rehabilitation Services for Alcohol and Substance Abuse.* Coverage is provided for rehabilitation services for alcohol and substance abuse when prescribed by a Plan Provider of an appropriate specialty. Rehabilitation service is therapy that is anticipated to result in significant clinical improvement within a reasonable period of time.
 - a. Maintenance therapy for chronic conditions is not a Covered Benefit.

J. Special Services, Equipment and Devices

1. *Diabetic Coverage.* Coverage for the treatment of diabetes includes:
 - a. *Diabetes equipment and related supplies.* Includes blood glucose monitors and blood glucose monitors for the visually impaired, data management systems, test strips for glucose monitors and visual reading and urine testing strips, insulin, injection aids, cartridges for the visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents for controlling blood sugar, and other additional diabetes equipment and related supplies as required by rules and regulations of the New York State Department of Health. Diabetes equipment must be authorized by a PCP or Specialist. Any diabetes equipment requires prior authorization by the MetroPlus Medical Director or his/her designee.
 - b. *Professional Services Consisting of Diabetes Self-Management Education.* If the Member is diabetic, coverage will be provided for education to ensure the Member is trained in the proper self-management and treatment of the Member's condition, including information on proper diet.

- Such education will be limited to visits when there is a diagnosis of diabetes, where a Participating Provider diagnoses a significant change in the Member's symptoms or conditions necessitating changes in self-management, or where reeducation or refresher education is necessary. Professional Services must be provided by a Plan Provider. Education provided by certified diabetes educators, certified nutritionists, certified dietitians or registered dietitians is limited to group settings wherever practicable. Coverage for self-management education and education relating to diet may also include home visits when Medically Necessary.
- c. *Insulin and Oral Agents for Controlling Blood Sugar.* Pharmacy will dispense up to a one (1) month supply at participating retail drug locations and up to a ninety (90) day supply through mail order, at a time.
 2. *Durable Medical Equipment.* Coverage is provided for Durable Medical Equipment (DME) as defined in Part I.I. when authorized by the PCP and the MetroPlus Medical Director or his/her designee.
 - a. Covered DME must meet Medical Necessity guidelines.
 - b. Repair, replacement and maintenance of authorized DME will be covered. Coverage is limited to normal wear and use and body growth/change. There is no coverage for equipment that has been abused or cared for improperly.

Covered Benefits are provided only for the basic item and any Medically Necessary special features prescribed by a Plan Provider and approved by the MetroPlus Medical Director or his/her designee.
 3. *Orthotics.* Coverage is provided for Orthotics as defined in Part I.X. Orthopedic shoes are covered if they are an integral part of the leg brace or prescribed by a Plan Provider and approved by MetroPlus Medical Director or his/her designee. Custom-made foot Orthotics or shoe inserts are covered once every three (3) years when prescribed by the PCP. Other supports for the feet are not covered.
 4. *Prosthetic Devices.* Coverage is provided for Prosthetics as defined in Part I.FF. Coverage is provided only for the basic prosthetic and any Medically Necessary special features prescribed by a Plan Provider and approved by MetroPlus. Prosthetics must be provided by a Participating Provider that has received authorization from the MetroPlus Medical Director or his/her designee. Replacements are limited to those necessary due to normal wear and use and body growth/change. There is no coverage for Prosthetic Devices that have been abused or cared for improperly.
 - a. *Internal Prosthetics.* Coverage is provided for internal Prosthetics including, but not limited to, pacemakers, heart valve replacements and artificial joints.
 - b. *External Prosthetics.* Coverage is provided for external Prosthetics including, but not limited to, artificial limbs or eyes, external breast prostheses, ostomy supplies and initial prescription lenses (eye glasses or contact lenses) following an operation for cataract or other diseases of the eye.
 - c. *Dental Prosthetics.* Internal or external dental Prosthetics are only covered when supplied in conjunction with a covered dental service as described in Part III.K.
 - d. *Wigs.* Wigs are covered only for medically induced hair loss.
 5. *Hearing Aids.* Coverage is provided for one hearing aid per year when authorized by the MetroPlus Medical Director or his/her designee.

K. Treatment for Accidental Injuries to Teeth and Non-Dental Oral Surgery

Dental services are not Covered Benefits except for the following limited oral surgical procedures in an inpatient or outpatient setting when prior authorized by a Plan Provider:

1. Dental care or treatment for accidental injury to sound natural teeth within twelve (12) months of the accident as long as the Member is covered at the time services are rendered.
2. Dental care or treatment necessary due to congenital disease or anomaly.

Part IV - Exclusions and Non-Covered Services

- A. Exclusions.** Except as described under Part III, Covered Services and Benefits, the following services are excluded from coverage under this Certificate:
1. Any cosmetic surgery. Cosmetic surgery shall not include reconstructive surgery which is incidental to or follows surgery resulting from trauma, infection or disease of the involved part, or reconstructive surgery because of congenital disease or anomaly of a Dependent child which has resulted in a functional defect. Whether surgery is cosmetic surgery is subject to review and prior authorization by the MetroPlus Medical Director or his/her designee.
 2. Dental care except as described in Part III.K.
 3. Care which, in the opinion of MetroPlus, is primarily for rest or custodial purposes. The determination of whether care is primarily for rest or custodial purposes is subject to Medical Necessity and may be appealed to an External Appeal Agent pursuant to an external review performed in accordance with Article 49 of the New York Public Health Law.
 4. Payment for services that would normally be provided without charge.
 5. Routine foot care including services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
 6. Eyewear and eye exams related to the need for glasses and contact lenses are not covered.
 7. Illness, accident, treatment or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
 8. Coverage while the Member is outside the United States, its possessions or the countries of Canada and Mexico.
 9. Treatment provided in a federal government hospital.
 10. Benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal Workers Compensation, employers' liability or occupational disease law.
 11. Benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
 14. Services rendered and separately billed by employees of hospitals, laboratories or other institutions.
 13. Services performed by a member of the Member's immediate family.
 14. Personal care services, private duty nursing and long-term home care except as described in Part III.D.1 and III.G.
- B. Non-Covered Services**
1. Services which are not Medically Necessary as determined by the MetroPlus Medical Director or his/her designee.
 2. Services rendered outside of the scope of a provider's license or certification.
 3. Infertility services in connection with:
 - a. In vitro fertilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT);
 - b. Reversal of elective sterilizations;
 - c. Sex change procedures;
 - d. Cloning; or
 - e. Medical or surgical services or procedures that are deemed Experimental/Investigative in accordance with the standards and guidelines established and adopted by American Society for Reproductive Medicine.
 4. Personal comfort or convenience items. Determinations of whether items are personal comfort or convenience items that are not Medically Necessary are subject to review by an External Appeal Agent pursuant to an external review performed in accordance with Article 49 of the New York Public Health Law. For further information on external appeals, please consult the MetroPlus Gold Member Handbook.
 5. Private Hospital rooms, unless determined to be Medically Necessary by MetroPlus.
 6. Services or treatment for mental retardation or chronic illness, the monitoring of medications prescribed for treatment of such conditions, or enrollment in special schools, except as described in this Certificate under Parts III.H and III.I.

7. In general, MetroPlus does not cover Experimental/Investigative Services or Items. However, MetroPlus Medical Director or his/her designee will review each request on a case by case basis for approval. MetroPlus will also cover an Experimental/Investigative Service or Item approved by an External Appeal Agent pursuant to an external review performed in accordance with Article 49 of the New York Public Health Law. If the External Appeal Agent approves coverage of an Experimental/Investigative Service or Item that is part of a clinical trial, MetroPlus will only cover the costs of Covered Services required to provide treatment to the Member according to the design of the trial. MetroPlus will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non-investigational treatments and which are provided in such clinical trials. For further information on external appeals, please consult the MetroPlus Gold Member Handbook.
8. Care for military service connected disabilities and conditions for which the Member is legally entitled to services and for which facilities are reasonably accessible to the Member.
9. Care for conditions that federal, state or local laws require to be treated in a public facility.
10. Pretrial or court testimony and the preparation of court related reports are not a benefit. Court ordered treatment for substance abuse or a mental condition is not a benefit except to the extent covered under this Certificate and in accordance with policies and procedures for authorization of services.
11. Marriage counseling.
12. Acupuncture.
13. Services related to another family member's alcohol and/or substance abuse rehabilitation except as provided in Part III.I.
14. Personal growth and/or educational requirements in conjunction with the mental health and substance abuse benefits.
15. Out-of-Network Services for health maintenance and preventive services.
16. Drugs and devices, including prescription drugs except as otherwise specified in this Certificate.
17. Any service, care, supply or equipment that is not specifically covered under Part III of this Certificate.

Part V - Plan Administration and Forms

- A. **Relationship of Parties.** The relationship between MetroPlus and Participating Providers is that of an independent contractor relationship. Participating Providers are not agents or employees of MetroPlus, nor is MetroPlus or any of its employees an employee or agent of Participating Providers. MetroPlus will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care through any Participating Providers.
- B. **Premium Payment.** The Premium charges will be determined by MetroPlus. Premium charges are determined according to the laws and regulations of the State of New York.
1. Premium payment is due on or before the first day of the billing period for which coverage is provided.
 2. Only when the Member's Premium payment has been received is the Member entitled to health care services under this Certificate. A grace period of ten (10) days will be allowed.
- C. **Changes in Certificate or Premium.**
1. MetroPlus reserves the right to change this Certificate or change Premium rates in accordance with the laws and regulations of the State of New York upon at least thirty (30) days prior written notice to the Group, if the change to the Certificate is approved by the Superintendent of Insurance.
 2. Changes to the Group Contract that affect the Member's coverage under this Certificate, including the elimination of Riders that provide additional benefits, become effective on the effective date of the change.
 3. Changes to this Certificate including, but not limited to changes to Covered Benefits, become effective on the effective date of the change.
- D. **Identification Cards.** Identification Cards are issued for the purpose of identification only. Willfully or knowingly permitting another person to use the Member's Identification Card to receive services constitutes fraud, and could result in the termination of the Member's coverage under this Certificate and could result in civil and/or criminal legal action against the Member.
- E. **Authorization to Review or Obtain Health Care Records.** The Employee and each of the Employee's Dependents agree that any Health Professional, Hospital, Workers Compensation Board, Plan or Other Insurance Carrier (including but, not limited to Indemnity, PPO, HMO, Workers Compensation, No-Fault, Medicaid and Medicare) is authorized to give MetroPlus, upon request, all information and records (or copies) relating to the Member's diagnosis or treatment necessary for treatment, payment and health care operations purposes.
- F. **Confidentiality of Health Care Records.** MetroPlus recognizes the Member's right to the confidentiality of the Member's medical/health information received from any source, including physicians, health professionals, hospitals and other health care providers, incident to the physician-patient or hospital-patient relationship. The Employee and each of the Employee's Dependents consent to MetroPlus' (and its agents') use of the Member's personal health information for treatment, payment and health care operations purposes. These purposes include, but are not limited to, disease prevention and management programs, coordination of health care treatment and benefits, utilization and claims review, quality assurance activities, complaint and dispute resolution processes, and certification and accreditation. MetroPlus will not otherwise disclose personally identifiable health information without the express consent of the Member or the Member's Dependents unless required by federal or state law or regulation, or by court order. The Member can get a full copy of MetroPlus' Privacy Notice by contacting MetroPlus Customer Services at 877-475-3795 (TTY 800-881-2812).
- G. **How to File a Claim.** The Member should not make payments to Participating Providers because MetroPlus will pay Participating Providers directly. If, however, authorized Covered Services are received from non-Participating Providers, MetroPlus reserves the right to pay either the Member or the provider. If the Member has paid for Covered Benefits, the Member may be reimbursed if:

1. The Member provides MetroPlus with an itemized bill including the diagnosis, date and place of service, a description, and the charge for each service rendered. The bill must clearly indicate the Provider's name, address, phone number and Tax Identification Number.
2. The Member makes the request for reimbursement within six (6) months of the date of service.
Requests should be made to:
MetroPlus Health Plan, Inc.
Attention: Customer Services Department
160 Water Street, 3rd Floor
New York, New York 10038

Part VI - Termination of Coverage

A. **Effective Dates**

1. In the event that coverage terminates for any reason, all Covered Benefits will end on the date of termination.
2. Covered Benefits are not vested. This means that the Member does not have any rights to continue receiving Covered Benefits after coverage terminates.

B. **Termination of Group Contract.** When the Group Contract is terminated, coverage for all Members enrolled through the Group Contract terminates. The Group Contract may be terminated:

1. By the Group, for any reason, on its anniversary date, with thirty (30) days written notice to MetroPlus.
2. By MetroPlus if the Group fails to pay the Premium for this Certificate when due, and if default continues after the grace period.
3. By MetroPlus if the Group has committed fraud or made an intentional misrepresentation of material fact.
4. By MetroPlus if no eligible employees work or reside in the Service Area.
5. By MetroPlus if MetroPlus terminates the entire class of contracts to which the Group Contract belongs, upon at least ninety (90) days prior notice of such termination.
6. By MetroPlus or Group for any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement provisions of the Act.

C. **Termination of Member Coverage.** A Member's coverage may be terminated:

1. By MetroPlus or Group for any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement provisions of the Act.
2. By the Group if the Member no longer meets the Group's eligibility requirements.
3. By the Member during the Member's Group's Open Enrollment.
4. By MetroPlus for failure of the Member's Group or the Member to make payment of Premiums or Co-payments or other charges due MetroPlus or Participating Providers.
5. By MetroPlus if the Member attempts or commits fraud in:
 - a. Submitting a claim for benefit;
 - b. Completing the initial application or subsequent dependent eligibility form;
 - c. Failing to notify MetroPlus of a change in eligibility for any Member ;
 - d. Willfully or knowingly permitting another person to use the Member's Identification Card.

Please note: If the Member is terminated for fraud or attempted fraud, the Member will not be eligible for any other MetroPlus coverage and MetroPlus will not be responsible for payment of any claims that result from fraud. MetroPlus may recover from the Member the cost of any services or items obtained by fraud.
6. By Group, Member or MetroPlus if the Member permanently resides outside of the Service Area or moves outside of the Service Area for more than three (3) months, except in cases where the Member continues to work within the Service Area.
7. By Group, Employee or MetroPlus for any Dependent Member who is no longer eligible for coverage as a Dependent.

Part VII - Benefits for Total Disability After Termination

If the Member is totally disabled on the date the Member's coverage under this Certificate terminates, MetroPlus will continue to provide coverage, but only for a condition causing total disability that is under treatment at the date of termination, and only until one of the following occurs:

1. The Member is no longer totally disabled;
2. The maximum benefit, if any, has been reached; or
3. A period of twelve (12) months from the date of termination has elapsed.

However, in no event will MetroPlus pay for more care than the Member would have been entitled to receive if the Member's coverage under this Certificate had not terminated. This provision applies only when the Member's coverage under this Certificate is terminated and not when this Certificate is changed according to Part V.C.

Part VIII - Conversion Privilege

- A. **Temporary Continuation.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Section 4305 of the New York State Insurance Law, most employer sponsored group health plans must offer employees and their families the opportunity for temporary continuation of coverage when their coverage would otherwise end. If the Member is not entitled to temporary continuation of coverage under COBRA, the Member may be entitled to temporary coverage under the New York State Insurance Law (State Law) as described below. Any continuation of coverage will terminate at the end of the period of continuation provided under COBRA or State Law. Under State Law, if the Member loses coverage because of termination of the Member's employment or loss of eligibility, the Member may continue coverage for himself/herself and the Member's eligible Dependents under the following conditions:
1. The Member is not entitled to Medicare and the Member is not covered under or eligible for other group coverage which does not exclude or limit coverage for pre-existing conditions.
 2. The Member requests continued coverage within sixty (60) days after the later of the date the Member's coverage ended or the date the Member was given notice of continuation by the Group.
 3. If the Member wants continuation because of a disability determination under Title II or Title XVI of the Social Security Act (SSA), the Member must notify the Group within sixty (60) days after a determination that the Member was disabled at the time the Member's employment was terminated or at any time during the first sixty (60) days of continuation of coverage.
 4. The Member pays the Premium when due. The Premium cannot exceed 102% of the Group Premium.
 5. Coverage terminates at the earliest of the following:
 - a. Expiration of thirty-six (36) calendar months after the Member's coverage would have terminated because of termination of employment;
 - b. The date to which Premiums are paid if the Member fails to make a timely payment;
 - c. Expiration of thirty-six (36) calendar months after the Member's coverage would have terminated due to the death of the Employee, divorce or legal separation, the Employee's eligibility for Medicare or the failure to qualify under the definition of "children";
 - d. Expiration of thirty-six (36) calendar months after the Member's coverage would have terminated because of termination of employment if the Employee is determined to have been disabled under the SSA at the time of termination of employment or at any time during the first sixty (60) days of continuation coverage; or
 - e. The date the Group no longer provides coverage to any of its employees.
- B. **Right to a New Contract After Termination.** The Member has a right to convert to a new contract (COBRA) if the Member's coverage under this Certificate terminates under certain circumstances.
1. Entitlement to a new contract. The Member may be entitled to purchase a contract with MetroPlus as a direct payment subscriber if:
 - a. The Group Contract is terminated for any reason and the Member's employer has not replaced the coverage for the group with similar and continuous coverage.
 - b. The Member's coverage under this Certificate is terminated due to:
 - (1) Termination of the Member's coverage under the Group Contract because the Member is no longer a member of the Group;
 - (2) Termination of the Member's temporary continuation of coverage;
 - (3) The death of the Employee;
 - (4) Termination of the Member's marriage; or
 - (5) The Member's loss of eligibility as a Dependent.

Part IX - Young Adult Option

- A. **Young Adult Coverage.** A Young Adult who exceeds the age limit for coverage under this Certificate may purchase coverage through this Group Contract through the age of twenty-nine (29).
- B. **Enrollment.** A qualifying Young Adult may elect coverage under this option and enroll as follows:
1. Within sixty (60) days of the date that he or she would otherwise lose eligibility for coverage under the parent's policy due to age;
 2. Within sixty (60) days of the dates when a change in circumstances qualifies the Young Adult for coverage;
 3. During the Group Open Enrollment period.
- C. **Termination.** Coverage under this option terminates when one of the following occurs:
1. The Young Adult voluntarily terminates coverage pursuant to the terms of this Certificate;
 2. The Young Adult's parent is no longer covered under this policy;
 3. The Young Adult no longer meets the eligibility requirements for this coverage;
 4. The required premium is not paid in full within the 30-day grace period; or
 5. The Group Contract is terminated and not replaced.

Part X - Coordination of Benefits, Third Party Payments and Double Coverage

- A. **No Duplication of Benefits.** MetroPlus will provide the Member with Covered Services within the limits of this Certificate. MetroPlus will not duplicate benefits or provide the Member with greater benefits than the actual expenses incurred. Benefits under this Certificate will be reduced to the extent that they are available or that reimbursement is payable under any other health benefits plan covering the Member whether or not a claim is made for the benefits.
- B. **Other Carrier Continuation of Coverage.** MetroPlus will not pay for Hospital care if the Member is a patient in a Hospital on the date his or her coverage under this Certificate becomes effective, to the extent coverage is provided under any other plan.
- C. **Coordination of Benefits.** A person may be covered under two (2) plans that provide similar coverage. If the service the Member receives is covered under both plans, MetroPlus will coordinate benefit payments with the other company. One company will provide its full benefit as a primary benefit. The other company will provide secondary benefits, if necessary, to the extent of its benefits. This prevents double payment and overpayment. In order to determine which company is primary, these rules apply whether or not a claim is actually made under both plans:
1. If coverage is available under any of the following plans or programs, that plan is primary:
 - a. Mandatory no-fault automobile insurance;
 - b. Workers Compensation insurance;
 - c. A student health plan issued by or through a college or other similar educational institution;
 - d. Any group or blanket insurance policy, including HMO or other prepaid group coverage, except that blanket school accident coverage and coverage issued to substantially similar groups shall not be considered a plan subject to this section; and
 - e. Any government program, except Medicaid. If the Member is entitled to Medicare Part A and eligible for Medicare Part B and no state or federal law requires that MetroPlus be the primary payer, MetroPlus will not pay the portion of any claim that Medicare will cover if the Member had obtained Medicare Part B coverage. This applies even if the Member has not obtained Medicare Part B coverage.
 2. If the other plan does not have a provision similar to this one, then it shall be primary.
 3. If the person receiving the benefits is the employee belonging to the group through which, or to which one plan was issued and is only covered as a dependent on the other plan, the plan under which he or she is the employee will be primary.
 4. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers that person (or that employee's dependent) as a laid off or retired employee.
 5. If two (2) or more plans cover the person receiving care as a dependent, then the plan of the parent whose birthday occurs earlier in the Calendar Year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. If, however, the other plan uses a rule based on the employee's gender and if, as a result, the plans do not agree on the order of benefits, the other plan will be primary.
 6. If the dependent is the child of divorced, unwed, or separated parents, then benefits for the child are determined in this order:
 - a. First, the plan of the parent with custody of the child;
 - b. Then, the plan of the spouse of the parent with custody of the child;
 - c. Finally, the plan of the parent not having custody of the child; and
 - d. Notwithstanding a, b, and c above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 7. If none of the above applies, then the plan that has been in effect for the longest time shall be primary.

8. The Member is required to cooperate with MetroPlus in the administration of this provision. If this Certificate requires that benefits be paid for by another plan and the Member has failed to seek payment from that plan, MetroPlus will reduce the payments under this Certificate by the amount to which the Member is entitled from the other plan. In some cases, MetroPlus may ask the Member to sign documents or cooperate with MetroPlus to seek payment from the other plan. The Member is required to cooperate in such cases.
9. None of the above rules as to coordination of benefits will serve as a barrier to the Member first receiving Covered Benefits under this Certificate.

D. **Subrogation.** In the event that the Member suffers an injury or illness for which another party may be responsible, such as someone injuring the Member in an accident, and MetroPlus pays benefits as a result of that injury or illness, MetroPlus may, in certain circumstances, be subrogated and succeed to the right of recovery against the party responsible for the Member's illness or injury and have a lien to the extent of the benefits MetroPlus has paid. Such subrogation shall be limited to a statutory right of reimbursement. By entering into a settlement, a Member shall not be deemed to have taken an action in derogation of any non-statutory right of MetroPlus in paying, or which MetroPlus is obligated to pay, for benefits for an injury or loss; nor shall a Member's plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider. If a plaintiff settles, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider, except for those payments as to which there is a statutory right of reimbursement.

Part XI - General Provisions

- A. Entire Contract.** The Group Contract, the Group’s application, this Certificate, along with the Explanation of Co-payments, any Riders, Enrollment Form, Member Identification Card, and any amendments added now or in the future constitute the entire Contract between MetroPlus, the Group, the Employees and enrolled Dependents. As of the effective date of this Certificate, all other agreements between the parties are superseded. By enrolling in MetroPlus, the Member agrees to abide by the terms and rules as described in this Certificate.
- B. Form or Content of Plan.** No agent or representative of MetroPlus, other than its President, is authorized to change this Certificate.
- C. Administration of Plan.** MetroPlus may adopt reasonable policies and procedures, rules and interpretations to promote its orderly and efficient administration. These actions will not alter this Certificate.
- D. Assignment.** This Certificate is not assignable by the Group or by the Member without MetroPlus’ written consent.
- E. Amendment.** MetroPlus may amend this Certificate as provided in Part V.C.
- F. Litigation for Payment.** The Member may not sue MetroPlus for refusing to pay for services unless the Member starts the suit within one (1) year from the date on which the services were provided or requested, whichever comes first.
- G. Legal Venue.** This Certificate is governed by the laws of the State of New York and any legal action must be brought and resolved in New York State.
- H. Notice.** When a notice is required under this Certificate, it can be directed to President, MetroPlus Health Plan, Inc., 160 Water Street, 3rd Floor, New York, New York 10038, and to the Group and/or to the Member at the most recent address on file with MetroPlus. The Member is required to inform MetroPlus of any change of address in a timely manner.
- I. Clerical Error.** Clerical error, whether of the Group or MetroPlus, in keeping any record pertaining to the coverage under this Certificate, will not invalidate the coverage otherwise validly in force or continue coverage otherwise validly terminated.
- J. Information.** Information as to how Covered Services may be obtained will be furnished to the Member after enrollment and may be obtained at any time upon request to MetroPlus Customer Services.
- K. Subtitles.** The subtitles included in this Certificate are provided for the purpose of identification and convenience and are not part of the complete Certificate.
- L. No Vesting.** There is no vesting of benefits or services under this Certificate. This means that absent regulatory or contractual provisions to the contrary, as of the effective date of a reduction, modification or change in benefits or service, the Member is entitled to receive only the level and type of benefits and services that are in effect as of that date, regardless of whether the Member previously had been receiving a higher level or type of benefit or service.
- M. Grandfathered Health Plan.** MetroPlus believes that this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Questions regarding which protections apply and which do not apply to a grandfathered health plan and what might cause MetroPlus to change from grandfathered health plan status can be directed to the MetroPlus plan administrator at President,

MetroPlus Health Plan, Inc., 160 Water Street, 3rd Floor, New York, New York 10038. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.