HIP®
HIP HEALTH PLAN OF NEW YORK ■ HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET, NEW YORK, NY 10041-8190

CITI GROUP
125 BROAD STREET
NEW YORK, NY 10004

DEAR MR. CITI GROUP:

Welcome to HIP! This welcome kit is designed to help you understand your HIP coverage and all that your plan offers. Please note that your new HIP Member Identification Card will be sent to you under separate cover.

Your member handbook and other very important information about your plan are included on the enclosed CD. If you need tips on using the CD, please see the following page. If you would prefer a printed copy of the information on the CD, you may request it by calling HIP's newly enhanced, automated, interactive voice response (IVR) system at **1(800) HIP-TALK (1-800-447-8255)**. Just select "forms and literature" when prompted.

You can also find information about your plan and obtain customer service assistance by visiting our Web site at **hipusa.com**[fi]. Our Web site is available 24 hours a day, seven days a week in English, Spanish, Chinese and Korean.

To ensure that you receive quality customer service from HIP, please help us keep your personal records accurate. Let us know if you have any change affecting your coverage (e.g., a name or phone number change, a change in marital status or the birth of a child) by following the instructions in the enclosed introductory brochure and in your member handbook.

If you need to speak with a Customer Service advocate, please call **1(800) HIP-TALK (1-800-447-8255)**, Monday through Friday, between 8 am and 6 pm. If you have a hearing or speech impairment and use a TDD, please call **1-888-447-4TDD (1-888-447-4833)** Monday through Friday, between 8:30 am and 5 pm. You may also visit us in person on weekdays, between 8:30 am and 5 pm at our Walk-In Center located in the 55 Water Street, New York, NY lobby. No appointment is necessary.

Thank you for choosing HIP. It's a pleasure and privilege to serve you.

Sincerely,

Daniel T. McGowan
President & Chief Operating Officer
HIP Health Plan of New York

Leslie Strassberg
President
HIP Insurance Company of New York

PS If your plan requires the selection of a Primary Care Physician (PCP) and you have not already selected a PCP, please do so promptly by calling our IVR or visiting hipusa.com today.

Member Name:	CITI GROUP
Effective Date:	01/01/2007
Center:	SUFFOLK NETWORK 55 WATER ST NEW YORK, NY 10041 (800) 447-8255
PCP:	ANTHONY GUIDA 373 SUNRISE HWY WEST BABYLON, NY 11704 (631) 422-3377

YOUR HIP CD-ROM

A FEW TECHNICAL TIPS

1. You put the CD-ROM in the computer, but nothing happens.

If you are using a Windows PC, click the "Start" menu button and then click the "My Computer" button option. This will open a window showing the drives that are active on your computer. Look for the drive labeled "HIP." Double-click on that drive and wait a moment. If the application does not start, right click on the drive labeled "HIP." From the list of options that appear, click the "Open" option. You will see a list of the CD-ROM contents. Double-click the item labeled "Start Here." This will launch the application introduction screen and menu.

If you are using a Mac, when you insert the disc into your drive, an icon for the drive will appear on your desktop labeled "HIP." Double-click the icon and a window showing the CD-ROM contents will appear. Double-click the item labeled "Start Here." This will launch the application introduction screen and menu.

2. You put the CD-ROM in your computer, your web browser opens but nothing happens.

Close the web-browser application that was opened when you inserted the CD. Then proceed to follow the instructions from TIP #1 above.

3. After you put the CD-ROM in your computer, the introduction screen opens and plays. When you click the Table of Contents button, however, nothing happens.

This may mean that you do not currently have the Adobe Acrobat Reader installed on your computer. Simply type in the link below in the address area of your web browser and install the FREE Adobe Acrobat Reader. After you have successfully installed the Adobe Acrobat Reader, try clicking the Table of Contents button again. The PDF file should launch either directly through the Adobe Acrobat Reader application or open the PDF with your web browser using the Adobe Acrobat Reader application so that you can view the file in your web browser window. This is dependent upon your computer and web browser preference settings.

Here is the link to the Adobe Web site where you can download the FREE Adobe Acrobat Reader application: **http://www.adobe.com/products/acrobat/readstep2.html**

4. When you click the Table of Contents button, the Adobe Acrobat file opens (*either through the Adobe Acrobat Reader directly or through the web browser*), however you get a message that says some features may not work.

This message may be appearing because the version of the Adobe Acrobat Reader you are using is an older version of the application. Depending on the actual version of the Adobe Acrobat Reader you are using, you may not even notice that some features are not working. If it appears, however, that features of the PDF are not working properly, you may want to upgrade your Adobe Acrobat Reader to the most recent version. This FREE upgrade is available through the Adobe Web site. The Adobe Web site for downloading the most recent version of the application is indicated in TIP #3 above.

HIP®

NEW MAIL ORDER PHARMACY VENDOR

January 2008

NOTICE

HIP welcomes its new mail-order pharmacy provider, Medco Health Solutions, Inc. (Medco®).

Effective January 14, 2008, HIP will no longer be using Express Scripts, Inc. and its affiliate, Curascript, for mail-order pharmacy services. Medco has replaced Express Scripts as HIP's mail-order pharmacy service provider.

If you have questions or need assistance with your mail-order prescription request, please call Medco at **1-800-457-1020** anytime, day or night. Members with a TDD device may call **1-800-759-1089**.

For questions about your benefits, including mail-order pharmacy services, please call HIP Customer Service at **1-800-HIP-TALK** (1-800-447-8255) Monday through Friday, 8 am to 6 pm. TTY/TDD users may call **1-888-HIP-4TDD** (1-888-447-4833) Monday through Friday, 8:30 am to 5 pm.

hipusa.com®
English, Spanish, Chinese and Korean

HIP®

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Details on your benefits – what's covered and what's not.

CERTIFICATE RIDERS

Information about any additional benefits available to you.

CONTRACT OR CERTIFICATE >>> OF COVERAGE

HIP®

HEALTH INSURANCE PLAN OF GREATER NEW YORK (HIP) and HIP INSURANCE COMPANY OF NEW YORK (HIPIC)

PRIME™POS

SCHEDULE OF BENEFITS

This Schedule of Benefits is a supplement to the Certificate of Coverage provided to Members and is not intended as a complete summary or explanation of the Services and Benefits covered or excluded. It is strongly recommended that Members review their Certificate of Coverage for an exact description of the Services and Benefits which are covered, those which are excluded or limited, and other terms and conditions of coverage. The Certificate of Coverage provided to Members is based on two contracts that HIP has sold to the Member's Group. These contracts are (1) a Group HMO Contract issued by Health Insurance Plan of Greater New York (HIP) and (2) a Group Insurance Policy issued by HIP Insurance Company of New York (HIPIC).

BENEFITS	IN-NETWORK VARIABLES Participating Providers	POINT OF SERVICE VARIABLES Non-Participating Providers
Inpatient Hospital Services[i]	$500 Copayment	Deductible & Coinsurance
Semi-private Room & Board	Included in Hospital Copayment	Deductible & Coinsurance
Staff Physician Services	Included in Hospital Copayment	Deductible & Coinsurance
Surgeon & Specialist Services	Included in Hospital Copayment	Deductible & Coinsurance
General Nursing Care	Included in Hospital Copayment	Deductible & Coinsurance
X-rays, Diagnostic Tests & Labs, Anesthetics and Prescribed Drugs	Included in Hospital Copayment	Deductible & Coinsurance
Operating & Recovery Rooms and Intensive & Specialty Care Units	Included in Hospital Copayment	Deductible & Coinsurance
Preadmission Testing	$0	Deductible & Coinsurance
Inpatient Speech, Occupational Cardiac, Respiratory and Physical Therapies	Not Covered	Deductible & Coinsurance
Ambulatory Surgery[1]	$75 Copayment	Deductible & Coinsurance
Primary Care Physician (PCP) Office Visits	$15 Copayment	Deductible & Coinsurance
Specialist Physician Office Visit	$25 Copayment	Deductible & Coinsurance
Preventive Care Screening	Included in Office PCP or Specialist Office Visit Copayment	Deductible & Coinsurance
Refractive Eye Exams	$0 Copayment	Deductible & Coinsurance
Diagnostic Laboratory Services	Included in Office Visit Copayment	Deductible & Coinsurance
Diagnostic and Therapeutic Radiology	Included in Office Visit Copayment	Deductible & Coinsurance
Dialysis Treatment	$25 Copayment	Deductible & Coinsurance
Chemotherapy	Same as Specialist Office Visit Copayment, Not to exceed $25	Deductible & Coinsurance
Chiropractic Services	Copayment Same as Specialist Office Visit Copayment	Deductible & Coinsurance
Pre-Hospital Emergency Services	$0 Copayment Copayment	Deductible & Coinsurance
Emergency Services		
In Physician's Office	Copayment same as PCP Office Visit Copayment	Deductible & Coinsurance

	IN-NETWORK VARIABLES Participating Providers	POINT OF SERVICE VARIABLES Non-Participating Providers
In Hospital Emergency Room[ii] In Urgent Care Facility	$50 Copayment same as PCP Office Visit	$50 Deductible & Coinsurance
Diabetic Supplies	$25 Copayment	Deductible & Coinsurance
Home Health Care	40 Visits $0 Copayment	Deductible & Coinsurance
Skilled Nursing Facility Care [1]	30 Days $0 Copayment	Not Covered
Hospice Care [1]	210 Days $0 Copayment	Not Covered
Mental Health		
Inpatient Treatment of Mental Illness[1]	30 Days Same as Inpatient Hospital Services Copayment	Deductible & Coinsurance
Inpatient Treatment of Biologically Based Mental Illness[1]	Unlimited days Same as Inpatient Hospital Services Copayment	Deductible & Coinsurance
Inpatient Treatment of Serious Emotional Disorders (Children)[1]	Unlimited Same as Inpatient Hospital Services Copayment	Deductible & Coinsurance
Outpatient Treatment of Mental Illness	20 Visits $25 Copayment	Deductible & Coinsurance
Outpatient Treatment of Biologically Based Mental Illness	Unlimited $25 Copayment	Deductible & Coinsurance
Outpatient Treatment of Serious Emotional Disorders (Children)	Unlimited $25 Copayment	Deductible & Coinsurance
Inpatient Detoxification Treatment of Chemical Abuse and Dependence [1]	7 Days Copayment Same as Inpatient Hospital Services	Deductible & Coinsurance
Inpatient Rehabilitation Treatment of Chemical Abuse and Dependence[1]	Not Covered	Not Covered
Outpatient Rehabilitation Treatment of Chemical Abuse and Dependence	60 Visits Up to 20 visits may be used by family Members. Copayment Same as Specialist Office Visit Copayment, Not to exceed $25	Deductible & Coinsurance
Outpatient Speech, Occupational Cardiac, Respiratory & Physical Therapies	30 Visits Same as Specialist Office Visit Copayment	Deductible & Coinsurance Deductible & Coinsurance
Family Planning Services	Yes	
Pre-Existing conditions Exclusion	Yes	
Dependent Coverage	Dependent children covered to age 19, end of year. Full-Time students covered to age 25, end of year.	

Provider Network

Member Pays:

Deductible:	$2,500 Family Deductible is **2** times the amount indicated above.
Coinsurance:	50%
Coinsurance Maximum:	$7,000 Per Calendar Year. Family Coinsurance Maximum is 2 times the amount indicated above.

Unless otherwise indicated, all day and visit limits are on a Calendar Year basis.

The covered in full POS benefit is solely for covered Inpatient Hospital Services, except for non-staff surgeon & specialist services. Professional services and other non-facility services will be subject to applicable deductible & coinsurance.

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[i] Prior Approval by the HIP Care Management Program is required for all Hospital and Facility Admissions, Ambulatory Surgery, Home Health Care, Hospice Care, Skilled Nursing Care.

[ii] The Hospital Emergency Services Copayment will be waived if the Member is admitted to the Hospital for treatment of the condition requiring Emergency Services. In such event, the Inpatient Hospital Services Copayment will apply.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIPIC PRIME® POS*

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK

CERTIFICATE OF COVERAGE

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

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

HIP Insurance Company of New York

Leslie Strassberg
President

Health Insurance Plan of Greater New York

Daniel T. McGowan
President

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PART I

GENERAL INTRODUCTION

PLEASE READ THIS CERTIFICATE CAREFULLY. THIS CERTIFICATE IS BASED ON TWO CONTRACTS THAT HIP HAS SOLD TO THE MEMBER'S GROUP. THESE CONTRACTS ARE (1) A GROUP HMO CONTRACT ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK (HIP) AND (2) A GROUP INSURANCE POLICY ISSUED BY HIP INSURANCE COMPANY OF NEW YORK (HIPIC). HMO BENEFITS AND SERVICES PROVIDED BY HIP ARE DESCRIBED IN PART II OF THIS CERTIFICATE. POINT-OF-SERVICE BENEFITS AND SERVICES COVERED BY HIPIC ARE DESCRIBED IN PART III OF THIS CERTIFICATE.

IN ORDER TO RECEIVE BENEFITS UNDER THIS CERTIFICATE, COVERAGE UNDER BOTH THE GROUP HMO CONTRACT AND THE GROUP INSURANCE POLICY IS REQUIRED.

IN ADDITION, WHENEVER VISITS ARE LIMITED UNDER THIS CERTIFICATE, SUCH LIMIT IS AN AGGREGATE OF COVERAGE UNDER PARTS II and III. FOR EXAMPLE, IF A MEMBER IS ALLOWED 60 VISITS FOR TREATMENT OF CHEMICAL ABUSE AND DEPENDENCE AND RECEIVES 30 VISITS UNDER PART II OF THIS CERTIFICATE, THEN (S)HE IS ONLY ALLOWED 30 ADDITIONAL VISITS UNDER PART III OF THIS CERTIFICATE.

PART II

HMO BENEFITS

SECTION ONE

INTRODUCTION AND DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIP means the Health Insurance Plan of Greater New York, an HMO organized under applicable state laws. HIP provides the Covered Services indicated under Part II of this Certificate.

HIPIC means the HIP Insurance Company of New York, an indemnity insurance carrier organized under applicable state laws. HIPIC provides coverage for the benefits and services indicated under Part III of this Certificate.

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

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

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

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

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

Identification Card means the card that is issued to Members upon enrollment. When a Member arrives at a Participating Provider to receive Covered Services, the Member must show the provider his or her Identification Card to verify coverage under this Certificate.

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

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

Member means any Subscriber or any Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION TWO

ROLE OF THE PRIMARY CARE PHYSICIAN

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

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

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

The PCP will obtain the required prior approvals from the HIP Care Management Program for:

- Inpatient and Outpatient Hospital Services
- Skilled Nursing Facility Services
- Ambulatory surgery
- Home Health Care
- MRIs/CAT scans
- Non-Emergency ambulance and transportation services

SECTION THREE

HOSPITAL SERVICES

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

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

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

Organ Transplants. Coverage is provided for organ transplants that are determined by HIP, in its sole discretion, to be non-Experimental or non-Investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. All covered transplants must be prescribed by the Member's PCP or other Participating Physician, and approved in advance by the HIP Care Management Program. Additionally, all transplants must be performed at Hospitals that HIP has specifically approved and designated to perform these procedures.

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

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

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

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

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

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

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

Short Term Speech, Occupational, Physical and Respiratory Therapy Services. Coverage will be provided for short-term speech, occupational, physical and respiratory services when a Member is admitted to a Hospital for treatment for a condition covered under this Certificate. Except, however, coverage is not provided when the sole reason that a Member is in a Hospital or any other facility is to receive speech, occupational, physical and/or respiratory therapy services.

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

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

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

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

Inpatient Rehabilitation Treatment of Chemical Abuse and Dependence. If indicated on the attached Schedule of Benefits, benefits are available for a limited number of days for inpatient rehabilitation treatment of chemical abuse and dependence.

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

OUTPATIENT HOSPITAL CARE

Covered Services. Subject to the Copay indicated on the attached Schedule of Benefits outpatient Hospital care shall consist of all services of Participating Providers as requested or directed by the PCP to be provided on an outpatient basis, including physical therapy, and radiation therapy, and services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy, ambulatory surgery, diagnostic and/or treatment services; x-rays and laboratory and pathological tests. As in the case of inpatient care, outpatient Hospital care and ambulatory surgery must be approved in advance by the HIP Care Management Program.

EXCLUSIONS AND LIMITATIONS

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

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

SECTION FOUR

MEDICAL SERVICES

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

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

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

The Member is entitled to the following Medical Services:

Preventive Health Services. This includes:

- Periodic physical examinations, clinical laboratory and radiological tests, ear and eye examinations, and all necessary health education and counseling services.
- Adult immunizations.
- Well child care services when ordered and performed by a Participating Provider shall be covered. These services include Physician-delivered or Physician-supervised visits from birth to 19, a medical history, a physical examination, developmental assessment and anticipatory guidance and appropriate immunizations (consisting of at least measles, rubella, mumps, haemophilus influenzae type b and hepatitis b which meet the standards approved by the United States Public Health Service for such biological products) and laboratory tests. Services including initial Hospital check-up and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law).
- One (1) baseline mammogram for any woman between thirty-five (35) and thirty-nine (39) years of age, inclusive.

- One (1) mammogram every two (2) Calendar Years, or more frequently, based on the Member's Physician's recommendation, for any woman who is forty (40) through forty-nine (49) years of age, inclusive.
- One (1) mammogram every Calendar Year if the Member is 50 years of age or older.
- One (1) or more mammograms per Calendar Year, based on Member's Physician's recommendation, for any woman who is at risk for breast cancer due to:

  I. a personal or family history of breast cancer;
  II. having a mother, sister or daughter who has had breast cancer; or
  III. a woman not having given birth before the age of thirty (30).
- One (1) cytology screening per Calendar Year for women age 18 or older, including an annual pelvic examination, collection and preparation of a Pap Smear, and laboratory and diagnostic services provided in connection with examinations and evaluating the Pap Smear.

Coverage for Newborn Children. Coverage for newborn children consists of coverage routine nursery care, injury or sickness, including necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is authorized by the attending Physician as necessary to protect the health and safety of the newborn child.

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

Chiropractic Services. In accordance with the attached Schedule of Benefits, the Member is entitled to receive chiropractic services from a Participating Provider in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation in the vertebral column. A PCP referral for chiropractic services is not required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION FIVE

OUTPATIENT SPEECH, OCCUPATIONAL, CARDIAC, RESPIRATORY AND PHYSICAL THERAPY

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

SECTION SIX

EMERGENCY SERVICES

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

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

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

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

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

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

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

SECTION SEVEN

OUTPATIENT TREATMENT OF MENTAL ILLNESS

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

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

SECTION EIGHT

OUTPATIENT REHABILITATION TREATMENT OF CHEMICAL ABUSE AND DEPENDENCE

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

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

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

SECTION NINE

HOME HEALTH CARE SERVICES

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

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

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

Coverage is not provided for care which HIP, in its sole judgment, determines to be primarily custodial. Custodial care is care which does not require the continuing attention of trained medical personnel. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include but are not limited to:

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

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

SECTION TEN

SKILLED NURSING FACILITY SERVICES

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

- In a Skilled Nursing Facility;
- Hospitalization would otherwise be necessary; and

- The Member must require skilled care, as defined in Section Ten above, which is required on a daily basis, is not primarily custodial as defined in Section Ten above, and can only be provided on an inpatient basis.

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

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

SECTION ELEVEN

HOSPICE CARE SERVICES

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

Hospice Care Services do not include the following:

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

SECTION TWELVE

EXCLUSIONS AND LIMITATIONS

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

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

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

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

Care Provided Outside of the HIP Service Area - Benefits are not available for services provided when the Member is traveling, visiting, or temporarily residing outside of the Service Area, except for Emergency Medical Conditions as defined in this Certificate.

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

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

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

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

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

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

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

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- The FDA has not granted the required approval for general use;
- A recognized national medical or dental society or regulatory agency has determined in writing, that it is experimental, investigational, or for research purposes;
- The written protocols or informed consent used by the treating facility or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure, or treatment state that it is experimental, investigational or for research purposes.

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

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

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

Government Hospital - Benefits are not available for care in any Hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the Hospital is a Participating Hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Temporomandibular Joint (TMJ) Syndrome - Benefits are not available for any diagnostic studies or treatment in connection with temporomandibular joint syndrome (TMJ) or disease, except treatment that is considered Medically Necessary and/or is incidental to or follows surgery from external trauma, infection or other diseases of the part of the body involved.

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

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

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

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

- Services required for a condition arising out of participation in a felony, riot or insurrection, suicide or intentionally self-inflicted injury. However, benefits are available for mental health services in connection with attempted suicide.
- Foot orthotics.
- Services required by participation in a war or act of war, whether declared or undeclared or by international armed conflict.
- Surgery or any related care (or after care) in connection with gender transformation.
- Services and supplies related to infertility treatment, including but not limited to artificial insemination, reversal of sterilization (male or female), any costs related to donors or semen banks, in-vitro fertilization or other artificial means of conception. Except that treatment for conditions that result in infertility are covered.

PART III

POINT OF SERVICE BENEFITS

SECTION ONE

INTRODUCTION AND DEFINITIONS

This Part III of the Certificate describes Point of Service benefits which are covered by HIP Insurance Company of New York (HIPIC) and unless otherwise indicated below, is subject to all of the terms, conditions, exclusions and limitations contained in Part II. This Part III, in conjunction with Part II of the Certificate, allows Members to elect to obtain Covered Services without a referral from their PCP.

When a Member obtains Covered Services which are not referred by his or her PCP, those services shall be considered Point of Service benefits and subject to Coinsurance and Deductible requirements, regardless of whether or not the services are rendered by a Participating or non-Participating Provider. However, Direct Access Medical Services obtained from Participating Providers without a referral from the PCP are not considered Point of Service benefits. Members may always obtain Direct Access Medical Services without a referral from their PCP and will be subject to the applicable HMO Copayment indicated on the Schedule of Benefits. Direct Access Medical Services are listed in Part I of the Certificate of Coverage.

Except as noted below, all Covered Services described in Part II of the Certificate as being covered when provided by Participating Providers are also covered as Point of Service benefits when provided by non-Participating Providers, subject to the Deductible and Coinsurance requirements indicated on the attached Schedule of Benefits. However, Members must always obtain the following benefits from Participating Providers: **adult preventive, including associated diagnostic services, Skilled Nursing Facility Care and Hospice Care Services.**

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

Coinsurance means a charge, expressed as a percentage of the provider's charge for services which the Member is required to pay when indicated under this Group Policy. The Member is responsible for the payment of any required Coinsurance charge directly to the provider when Covered Services are received. The Coinsurance, if any, shall be set forth on the attached Schedule of Benefits.

Deductible means the amount a Member must pay for Covered Services before HIPIC begins to pay any costs associated with Covered Services. The applicable Deductible, if any, is set forth on the attached Schedule of Benefits.

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

SECTION TWO

SCHEDULE OF BENEFITS

The applicable Coinsurance and Deductible amounts are identified on the Schedule of Benefits. All Point of Service benefits are subject to the Deductible and Coinsurance shown on the Schedule of Benefits. The Member must satisfy an annual Deductible as indicated on the Schedule of Benefits. After the annual Deductible is satisfied, HIPIC will reimburse claims according to the Coinsurance indicated on the Schedule of Benefits. After the Member satisfies the Coinsurance Maximum indicated on the Schedule of Benefits, HIPIC will reimburse 100% of Usual and Customary Charges or the Provider's charges, whichever is less. The following do not count toward the Deductible, Coinsurance and Coinsurance Maximum:

- • Any amounts paid for services not covered under the Certificate.
- • The difference, if any, between the Provider's actual charges and the amount HIPIC, in its sole discretion, deems to be Usual and Customary.
- • Any penalty due to failure to obtain prior approval from the HIP Care Management Program for certain services indicated herein.

Special Rules Applicable to the Calculation of Deductible and Coinsurance. After the Member has satisfied an individual Deductible, benefits will be payable for Covered Services. If family coverage was selected, after the Subscriber and Dependents have satisfied the family Deductible, no further deductible will be applied for the rest of the Calendar Year.

If family coverage was selected, once the sum of the individual Deductibles satisfied for the Calendar Year reaches the Family Deductible requirement, no further Deductible will be required from any family member covered under this Certificate for the remainder of the Calendar Year. The maximum amount for any family member which HIPIC will apply towards satisfying the Family Deductible is his/her individual Deductible.

Deductible Carryover. Any Deductible expenses incurred under this Certificate during October, November and December of a Calendar Year will be credited towards the Deductible Members must satisfy in the next Calendar Year.

SECTION THREE

PRIOR APPROVAL REQUIREMENTS

Members must comply with the provisions described in this Section before HIPIC pays benefits for certain services indicated herein. Failure to comply with the provisions of this Section will result in reduced payments. PLEASE READ THIS SECTION CAREFULLY.

Members must notify and obtain prior approval in advance from the HIP Care Management Program prior to receiving the following services:

- All inpatient admissions (non-emergency), including mental health and chemical abuse and dependence related admissions.
- Non-emergency outpatient Hospital services.

- All ambulatory surgery services.

The telephone number and additional details about the HIP Care Management Program is located in the HIP Member Handbook.

Members must call the HIP Care Management Program at 1-888-447-2884 at least seven (7) days in advance. The HIP Member advocate will ask for certain information (e.g., name of hospital, diagnosis, etc.) to determine that the admission or the surgery is Medically Necessary and appropriate. Once the HIP Care Management Program is notified, HIP will review the information provided and determine whether the services are Medically Necessary and Appropriate. This review will be performed by medical professionals and specially trained registered nurses and their determination will include, but is not limited to, the most appropriate inpatient or outpatient setting, an appropriate initial length of inpatient stay or outpatient course of treatment.

Failure to comply with provisions described above, will result in HIPIC reducing benefits otherwise payable by fifty percent (50%). Additionally, HIP does not pay benefits for any charges incurred which HIPIC determines not to be Medically Necessary and Appropriate. This includes, but is not limited to, inpatient care and treatment which could have been provided on an outpatient basis or in an alternate care facility. Any reduction in benefits otherwise payable will not count toward the Deductible and Coinsurance amounts shown on the Schedule of Benefits.

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

Any decision not to follow the recommendations of HIP and/or HIPIC is solely the Member’s Choice. These provisions are not designed to disturb any physician-patient relationship; nor are they meant to prohibit a Member from seeking any recommended medical care or treatment. A recommendation from HIP does not prohibit the Physician from providing care or treatment.

SECTION FOUR

FILING A CLAIM

Filing of Claims. Members who obtain Point of Service benefits must file a claim for reimbursement within 90 days of receiving the bill from the Provider. The address for filing claims will appear on the back of the Identification Card. Prompt filing of a completed claim form will result in faster payment of the claim.

Members may call 1-800-HIP-TALK to request claims forms. HIPIC will provide the claims forms within 15 days of such request. If said claims forms are not provided within the indicated timeframe, the Member will be deemed to have complied with the timeframes required by HIPIC to file said claim. Claim forms contain the instructions necessary to complete and send them. Proof of loss must be submitted with the completed form. Unanswered sections may delay processing of the claim. A Physician or health care provider will normally show his or her charges in the provider section of the claim form. If there are additional charges that are not shown on that section, Members must attach the original bill as proof of loss. These bills must show the Member's name, the date(s) of service, provider's name and service rendered, diagnosis or condition treated and the amount charged. If care and treatment continue over a period of time, Members should submit bill periodically. Do not submit one claim covering more than one person; separate proof of loss is required for each person. Cancelled checks, cash register or credit card receipts, or self-compiled lists are not acceptable as proof of loss.

Payment of Claims. Benefits will be paid upon adjudication of the claim. Benefits are payable to the Member or his or her legal representative, upon receipt of a valid authorization. If there is no representative, payment will be made to any health care provider who is entitled to payment for the services rendered. If any accrued benefits remain unpaid at the time of death, they will be paid to any health care provider who is entitled to payment for the same. Any additional unpaid benefits will then be paid to any relative related to the Member by blood or marriage. HIPIC is not liable for any benefit payments made in good faith.

Examinations. HIPIC reserves the right to have a Physician of its choice examine a Member who has made a claim for benefits under this Certificate. HIPIC may do this at reasonable intervals. HIPIC also reserves the right to require an autopsy unless it is prohibited by law. Any examination or autopsy so requested will be at HIPIC's expense.

Assignments. Members may authorize HIPIC to pay any benefits directly to the Physician or other health care provider from whom he or she received Covered Services. HIPIC may assign or delegate any administrative functions under this Certificate to any other subsidiary, related or successor entity.

SECTION FIVE

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations set forth in Part I of this Certificate, the following benefits and services are not covered:

- Adult preventive care
- Hospice Care
- Skilled Nursing Facility Care

PART IV

GENERAL ADMINISTRATION

This Part IV describes the administrative rules applicable under this Certificate. The benefits and services covered under this Certificate are based on a Group HMO Contract issued by HIP and a Group Insurance Policy issued by HIPIC. In most cases, administrative functions described herein are performed jointly by HIP and HIPIC. As a result, in this Part IV of the Certificate reference may be made jointly to both HIP and HIPIC. Unless otherwise indicated, all references to HIP shall mean both HIP and HIPIC.

SECTION ONE

ELIGIBILITY

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

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

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

C. Unmarried children of the Subscriber who are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined under applicable state law, or because of physical handicap. The condition must have occurred before the child reached the age indicated on the Schedule of Benefits. The child's disability must be certified by a Physician. In addition, HIP may require proof that the child remains eligible for coverage under this Certificate. Failure to submit the required proof may result in termination of coverage under this Certificate. In any event, coverage will terminate on the date it is determined that the child is no longer incapable of self-support.

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

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

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

- A legally adopted child.
- A child for whom the Subscriber is the legal guardian and who is chiefly dependent upon the Subscriber for support and meets the criteria for dependent eligibility established under Section 152 of the United States Internal Revenue Code.
- A child for whom the Subscriber is the proposed adoptive parent and who is dependent upon the Subscriber during the waiting period prior to the adoption becoming final.

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

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

- The Subscriber takes physical custody of the infant as soon as the infant is released from the hospital after birth; and
- The Subscriber files an adoption petition pursuant to applicable state law within thirty (30) days after the infant's birth.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION TWO

COORDINATION OF BENEFITS

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

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

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

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

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

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

   1. the plan of the parent who has custody (the custodial parent) shall be primary;

   2. if the custodial parent has remarried, and the child is also covered as a dependent under the stepparent's plan, the custodial parent's plan shall pay first, the stepparent's plan shall pay second and the non-custodial parent's plan shall pay third.

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

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

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

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

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

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

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

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

As used throughout this provision, the term "third party" means any party possibly responsible for making any payment to the covered person for any injuries or any insurance coverage, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers compensation coverage or no-fault automobile insurance coverage. As used throughout this provision, the term "covered person" means the injured person or persons or any of their agent, representatives, assignees, guardians, heirs or beneficiaries.

The covered person shall do nothing to prejudice HIP's subrogation and reimbursement rights and shall, when requested, cooperate with HIP's efforts to recover its benefits paid. It is the duty of the covered person to notify HIP within 45 days of the date when any notice is given to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person. The penalty for failing to cooperate as indicated above is that the covered person will be responsible to repay to HIP the cost of the benefits and services provided.

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

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

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

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

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

SECTION THREE

TERMINATION OF COVERAGE

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

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

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

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

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

SECTION FOUR

EXTENSION AND CONTINUATION OF COVERAGE

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

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

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

- Incapable of self-sustaining employment because of physical handicap or mental illness, mental retardation or developmental disability as defined under applicable state laws.
- Chiefly dependent upon the subscriber for support and meets the criteria for Dependent eligibility under Secton 152 of the United States Internal Revenue Code.
- Incapacitated prior to age indicated on the Schedule of benefits.

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

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

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

B. If the Subscriber is a retiree or a retiree's widow(er) and the Group commences bankruptcy proceedings, he or she may elect continuation coverage until death.

C. If the Subscriber becomes eligible for Medicare, dies, divorces or legally separates from a spouse covered under this Certificate, the former spouse and the dependent child(ren) may elect continuation coverage for 36 months.

D. HIP or the Group will send eligible Members an election notice when group coverage terminates. Eligible Members have sixty (60) days to make the election and forty-five (45) days from the date of election to pay the first premium. The Member must then remit future payments in a timely manner.

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

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

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

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

SECTION FIVE

RIGHT TO A NEW CONTRACT

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

Upon request, HIP will send a direct payment contract application, benefit summaries and other required information regarding its direct payment plans. HIP must receive, by certified mail, return receipt requested, a completed application and any premium due within forty-five (45) days after coverage terminates under this Certificate. This forty-five (45) day period may be extended if notice is not given on a timely basis.

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

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

SECTION SIX

DISPUTES UNDER THIS CERTIFICATE

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

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

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

Time to Sue. Any lawsuit under this Certificate must commence within two (2) years from the date of the service in question. Any legal action must be commenced in the State of New York.

SECTION SEVEN

GENERAL PROVISIONS

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

Medical Records. From time to time it may become necessary for HIP to obtain a Member's medical records and information providers, as well as other insurers or group health plans. All HIP Members under this Certificate, agree and authorize HIP, Participating Providers and non-Participating Providers to permit the examination and copying of any portion of said Members' Hospital or medical records, when requested by HIP. All Members enrolling with HIP expressly authorize HIP to obtain and use such information consistent with the administration of this Certificate. Additionally, if potential fraud is suspected, HIP has the right, without consent of the Member or Group, to review, including but not limited to, medical records, enrollment records and other relevant information needed to verify services.

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

- New HIP employees are instructed in medical record confidentiality requirements. They must sign a confidentiality statement of understanding. Each year of their employment, they must reaffirm their understanding of the importance of HIP's medical record confidentiality policy.
- To manage the security and routing of Member medical records, Participating Providers must also maintain medical records departments that are regularly instructed in and observe confidentiality procedures.
- HIP may receive copies of Member medical records during the course of business, such as when a claim is submitted. Copies of medical records are securely stored and reviewed only by designated employees with a need to know the information. As soon as the specific need has been fulfilled, copies of medical records are securely filed or destroyed.

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

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

Referrals to Nonparticipating Providers with Specialty Expertise. If HIP does not have a Participating Provider with the appropriate training and experience to meet the particular health care needs of a Member, the Member may obtain a referral to a health care provider outside of HIP's network of Participating Providers. The Member must first seek care through his or her HIP PCP and any specialists referred by the PCP. Then, if the PCP determines that the Member requires a referral to a Non-Participating Provider, the PCP will refer the Member for such a specialty consultation. The PCP will develop a treatment plan with the Member and the Non-Participating Provider. Once the plan is approved by HIP, this care will be provided to the Member as if the Non-Participating Provider were a HIP Participating Provider. The Non-Participating Provider must agree to accept HIP's usual rates as payment in full.

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

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

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

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

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

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

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

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

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

- Continues to accept HIP's rates of reimbursement for the Member's care.
- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to the Member's care.
- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior approval requirements.

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

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

- Accept HIP's reimbursement rates as payment in full for the services provided to the Member.
- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to the Member's care.
- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior approval requirements.

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

RIDERS >>>

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HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET - NEW YORK, NEW YORK 10041

RIDER TO BE ATTACHEDTO YOUR GROUP POLICY/CERTIFICATE ISSUED BY
HEALTH INSURANCE PLAN OF GREATER NEW YORK and
HEALTH INSURANCE PLAN INSURANCE COMPANY OF NEW YORK

CONTRACEPTIVE DRUGS AND DEVICES RIDER

This Rider provides benefits for Prescription Contraceptive Drugs and Devices under the provisions described below:

Definitions.

A. **"Brand Name Drug"**is a drug, which is approved by the Food and Drug Administration ("FDA") and protected by the trademark registration of the pharmaceutical company, which produces it.

B. **"Drug Formulary"**is a list of items, which may be dispensed by Participating Pharmacies to HIPIC members. This list consists mainly of prescription drugs but also includes some non-prescription drugs and nutritional supplements for the therapeutic treatment of phenylkenoturia and related disorders. This list is prepared by us and periodically reviewed and modified.

C. **"Generic Drug"**is a drug that has been approved by the FDA as therapeutically equivalent to a brand-name drug.

D. **"HIPIC Participating Pharmacy"**is a pharmacy which is owned and operated by HIP Health Plan of New York or one which has an agreement with us to provide covered prescription drugs and other items to HIPIC members.

E. **"Prescription Contraceptive Drugs and Devices"**is a drug or device which has been approved for use by the FDA and which by law is required to bear the legend "Caution - Federal Law prohibits dispensing without prescription" (Legend).

CONTRACEPTIVE DRUGS AND DEVICES RIDER

Benefits.

A. The item prescribed must be filled at a HIPIC Participating Pharmacy. The prescribed device must be administered by a Participating Provider, subject to the Direct Access Medical Services provisions of the Certificate. In no event shall the copay indicated below, if any, exceed the cost of the item prescribed.

B. **Formulary Benefit**
The prescribed item must be on the Drug Formulary. If the item needs to be compounded, it must contain Prescription Drugs listed in the Drug Formulary.

Copay Benefit

The Member pays the HIPIC Participating Pharmacy $7 for every 30-day supply (or less) of a Generic Drug, and $30 for every 30 days supply (or less) of the Brand Name Drug. If HIPIC's mail order service is used, these copays are reduced by 50%.

The Member pays the Specialty Pharmacy Program Provider $7 for every 30-day supply (or less) of a Generic Drug, and $30 for every 30 days supply (or less) of the Brand Name Drug.

C. **Non-Formulary Benefit**
The prescribed item is not required to be on the Drug Formulary. If the item is not on the Drug Formulary the copay is as follows:

Copay Benefit

The Member pays the HIPIC Participating Pharmacy $50 for every 30-day supply.

The Member pays the Specialty Pharmacy Program Provider $50 for every 30-day supply.

Exclusions.

A. Experimental drugs not approved by the FDA, drugs with no approved FDA indications and DESI (Drug Efficacy Study Implementation) products, i.e., those rated by the FDA as not proven safe and effective. Except, however, that coverage will be provided if an External Appeal Agent approves coverage of an experimental or investigational drug.

B. Non-prescription, over the counter contraceptive drugs and devices.

C. Drugs and devices for use in connection with (a) elective termination of pregnancy (b) the reversal of elective sterilization, (c) sex change procedures, (d) cloning or (e) experimental medical and surgical procedures.

D. Lost, stolen or destroyed drugs and devices.

Limitations

A. Any prescription which the pharmacist, in the exercise of his/her professional judgment, decides should not be filled. In such a case, the pharmacist will call the practitioner who wrote the prescription to determine the appropriate course of action.

B. More than 11 refills per prescription or refills dispensed more than 12 months after the original date of the prescription.

Signed for Health Insurance Plan of Greater New York

Daniel T. McGowan
President

Health Insurance Plan Insurance Company of New York.

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

The Policy/Certificate provides that all of its provisions and conditions not inconsistent with the provisions and conditions referred to herein shall apply to this coverage. All other term, conditions, limitations and exclusions of the Policy/Certificate apply. This amendment is effective for a Policy/Certificate issued or renewed on or after January 1, 2003.

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK
AND HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET - NEW YORK, NEW YORK 10041

RIDER TO BE ATTACHED TO YOUR CONTRACT/CERTIFICATE OF COVERAGE
ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK
AND HIP INSURANCE COMPANY OF NEW YORK.

DIALYSIS TREATMENT SERVICES AMENDMENT RIDER

The Dialysis Treatment Services provision in the Hospital Services section of the Certificate is amended as follows.

Dialysis Treatment Services. HIPIC pays for Dialysis Treatment Services on a walk-in basis in a Hospital or in a free-standing dialysis facility appropriately licensed under state law. When Medically Necessary and Appropriate, HIPIC pays for peritoneal Dialysis Treatment Services at home, including the rental costs of equipment. However, HIPIC will not pay for any furniture, electrical or other fixtures or for professional assistance needed to perform the dialysis treatments at home.

HIPIC pays for Dialysis Treatment Services for members with End Stage Renal Disease (ESRD) for the first thirty-three (33) months. Medicare will pay for Dialysis Treatment Services after the thirty-three (33) month period has ended.

Signed for:

Health Insurance Plan of
Greater New York

Daniel T. McGowan
President

HIP Insurance Company of
New York

Leslie Strassberg
President

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK 55 WATER STREET - NEW YORK, NEW YORK 10041

RIDER TO BE ATTACHED TO YOUR CERTIFICATE OF COVERAGE ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK.

This Rider provides the following benefits described below:

Definitions.

A "Covered Appliance" means one of the following items when prescribed by a Physician.

1. Durable Medical Equipment, which is:
   A. Primarily and customarily used to serve a medical purpose;
   B. Generally not useful to a person in the absence of illness or injury;
   C. Appropriate for use in the home;
   D. Medically Necessary and Appropriate for the care and treatment of the Member's illness or injury.
2. Prosthetic devices which replace all or part of an internal body organ or external limb. Eyeglasses, hearing aids and dental prosthetics, including dentures, are not covered.
3. Orthopedic devices which are required for the treatment of injuries or disorders of the skeletal system and associated muscles, joints and ligaments. Corrective or orthopedic shoes are not covered, unless HIP determines that the Member's condition requires a corrective shoe that can only be made from a mold or cast of his or her foot.

Dental prosthetics needed due to an accidental injury to sound natural teeth if the service is provided within twelve (12) months of the accident and necessary in treatment due to congenital disease or anomaly will be covered.

Benefits.

A "Deductible" is a charge that the Member is required to pay out-of-pocket for items covered under this Rider. The Member is responsible for payment of the Deductible directly to the Participating Provider. The Deductible is applicable to each Member covered under the Certificate and will not count toward any maximum out-of-pocket expenses under the Certificate.

Members must obtain all Covered Appliances from a Participating Provider. Covered Appliances are subject to a $0 annual Deductible.

The Member must obtain prior approval from HIP Care Management Program (CMP). Failure to follow all of the requirements of HIP CMP will result in denial of coverage for services. Please refer to the HIP Member Handbook for details about HIP CMP.

Signed for Health Insurance Plan of Greater New York and HIP Insurance Company of New York

Daniel T. McGowan
President

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All other terms, conditions, limitations and exclusions of the Certificate shall remain unchanged.

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK 7 WEST 34TH STREET - NEW YORK, NEW YORK 10001

RIDER TO BE ATTACHED TO YOUR CERTIFICATE OF COVERAGE ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK.

The Rider provides the dental benefits described below.

- One examination (comprehensive or periodic) every six months - $5 per visit.
- One prophylaxis (cleaning) every six months - $10 per visit.
- One topical application of fluoride (for children age 16 and under) every six months - $5 per visit.

Additional services, including but not limited to x-rays, fillings, crowns or dentures will be provided at a discounted rate subject to a fee schedule, which may change from time to time. Please refer to your HIP Directory of Providers for more details on how to obtain dental care under this Rider.

Members must use a participating HIP dentists for all care under this Rider. All fees must be paid directly to the participating HIP dentists.

Signed for Health Insurance Plan of Greater New York and HIP Insurance Company of New York

Daniel T. McGowan
President

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All other terms, conditions, limitations and exclusions of the Certificate shall remain unchanged.

HIP®
HEALTH PLAN OF NEW YORK

HIP®
INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK and
HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET, NEW YORK, NEW YORK 10041

AMENDMENT TO BE ATTACHED TO YOUR GROUP CONTRACT/POLICY/CERTIFICATE OF COVERAGE ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK and HIP INSURANCE COMPANY OF NEW YORK

MENTAL ILLNESS RIDER

This Rider amends Inpatient and Outpatient coverage for Mental Illness as described below: All capitalized terms used herein are defined in the Certificate of Coverage.

The definition of Mental Illness is deleted from the Introduction and Definitions section, in its entirety, and is replaced with the following:

Mental Illness means any disorder, regardless of its origin, that is a clinically significant behavioral or psychological syndrome or illness that substantially impairs a person's behavior, emotional reaction, thought process or ability to function in major life activities. All such Mental Illness must be classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

The definition of Chemical Abuse and Dependence is added in the Introduction and Definitions section, as follows:

Chemical Abuse and Dependence means any condition caused by regular excessive use of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and /or personal or social functioning. All such Chemical Abuse and Dependence conditions must be classified as a chemical substance-related disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under the Certificate of Coverage.

The definition of Facility is added in the Introduction And Definitions section, as follows:

Facility means an outpatient facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health.

The definition of Partial Hospitalization is added in the Introduction and Definitions section, as follows:

Partial Hospitalization means outpatient treatment of Mental Illness in a Facility where coverage is provided as an offset to Medically Necessary and Appropriate inpatient Hospital services at a ratio of two (2) Partial Hospitalization visits to one (1) inpatient Hospital day.

MENTAL ILLNESS-cont

The Hospital Service provision is amended as follows:

Inpatient Treatment of Mental Illness. Coverage is provided for Medically Necessary and Appropriate inpatient Hospital services associated with Mental Illness. Coverage includes inpatient Hospital services for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker. Inpatient treatment of Mental Illness is limited to the number of days indicated on the attached Schedule of Benefits and is consistent with the coverage provided for other Acute inpatient Hospital services.

Inpatient Treatment of Biologically Based Mental Illness. Subject to the attached Schedule of Benefits coverage is provided for Medically Necessary and Appropriate inpatient Hospital services associated with biologically based Mental Illness. Coverage includes inpatient Hospital services for the diagnosis and treatment of biologically based Mental Illnesses,including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker.The coverage for biologically based Mental Illness is consistent with the coverage provided for other Acute inpatient Hospital services. Covered biologically based Mental Illness are Schizophrenia/psychotic disorders, Major Depression, Bipolar Disorder, Delusional Disorders, Panic Disorder, Obsessive Compulsive Disorder, Bulimia, Anorexia and Binge Eating.

Inpatient Treatment for Children With Serious Emotional Disorders. Subject to the attached Schedule of Benefits coverage is provided for Medically Necessary and Appropriate inpatient Hospital services for children under age eighteen (18) with attention deficit disorder, disruptive behavior disorders or pervasive development disorders which are accompanied by one or more of the following symptoms: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that place the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that place the child at substantial risk of removal from the household. Coverage includes inpatient Hospital services for the diagnosis and treatment of serious emotional disturbances in children,including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker.The coverage for children with serious emotional disturbances is consistent with the coverage provided for other Acute inpatient Hospital services.

MENTAL ILLNESS RIDER-cont

The Outpatient Treatment of Mental Illness provision is amended as follows:

Outpatient Treatment of Mental Illness. Subject to the attached Schedule of Benefits coverage is provided for Medically Necessary and Appropriate treatment of Mental Illness on an outpatient basis. Coverage includes outpatient Hospital, Partial Hospitalization and outpatient Facility services for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker. Outpatient treatment of Mental Illness is limited to the number of days indicated on the attached Schedule of Benefits and is consistent with the coverage provided for other outpatient services.

Outpatient Treatment of Biologically Based Mental Illness. Subject to the attached Schedule of Benefits coverage is provided for Medically Necessary and Appropriate outpatient Hospital and outpatient Facility services associated with biologically based Mental Illness. Coverage includes outpatient Hospital and outpatient Facility services for the diagnosis and treatment of biologically based Mental Illnesses,including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker.The coverage for biologically based Mental Illness is consistent with the coverage provided for other outpatient Hospital and outpatient Facility services. Covered biologically based Mental Illness are Schizophrenia/psychotic disorders, Major Depression, Bipolar Disorder, Delusional Disorders, Panic Disorder, Obsessive Compulsive Disorder, Bulimia, Anorexia and Binge Eating.

Outpatient Treatment for Children With Serious Emotional Disorders. Subject to the attached Schedule of Benefits coverage is provided for Medically Necessary and Appropriate outpatient Hospital and outpatient Facility services for children under age eighteen (18) with attention deficit disorder, disruptive behavior disorders or pervasive development disorders which are accompanied by one or more of the following symptoms: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that place the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that place the child at substantial risk of removal from the household. Coverage includes outpatient Hospital and outpatient Facility services for the diagnosis and treatment of serious emotional disturbances in children,including the professional services of a psychiatrist, psychologist and/or licensed clinical social worker.The coverage for children with serious emotional disturbances is consistent with the coverage provided for other outpatient Hospital and outpatient Facility services.

When outpatient treatment of Mental Illness, biologically based Mental Illnessor treatment for children with serious emotional disordersis provided in a Facility inside New York State, the Facility must be certified by the State of New York Commissioner of Mental Health, operated by the State of New York Office of Mental Health.

Outside of New York State HIP will pay for such Covered Services that are received in a facility whose mental health treatment program has been approved by the Joint Commission on the Accreditation of Healthcare Organizations.

The diagnosis and treatment of Chemical and Substance Abuse are not Covered Services under this rider but such coverage may be provided elsewhere in the Certificate of Coverage. Any inpatient or outpatient Hospital services received for Chemical Abuse and Dependence will not count toward the coverage and limitations provided under this rider.

Signed for

Health Insurance Plan of Greater New York

Daniel T. McGowan
President

HIP Insurance Company

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

The coverage provided under this Rider is effective for health benefit plans issued, renewed or amended on or after January 1, 2007. All other term, conditions, limitations and exclusions of the Group Contract/Certificate of Coverage shall remain unchanged.

HEALTH PLAN OF NEW YORK

HEALTH INSURANCE PLAN INSURANCE COMPANY OF NEW YORK
7 WEST 34TH STREET - NEW YORK, NEW YORK 10001

AMENDMENT TO BE ATTACHED TO YOUR HIPIC POLICY/CERTIFICATE OF COVERAGE ISSUED BY HIPIC.

INFERTILITY DIAGNOSIS AND TREATMENT SERVICES AMENDMENT

The HIPIC Certificate is amended by deleting all references to infertility and by adding the following:

Definitions.

1. **"Infertility"** means the inability to have fertilization of an ovum for a period of twelve or more months.

2. **"Infertility Covered Services"** as used herein means those services and supplies that are described in this Amendment for the diagnosis and treatment of Infertility.

Infertility Covered Services.

When approved in advance by the HIPIC Care Management Program, HIPIC will pay for the Medically Necessary and Appropriate diagnosis and treatment of Infertility. Infertility diagnosis and treatment shall include coverage for medical and surgical procedures that would correct malformations, disease or dysfunction resulting in Infertility. Such coverage shall also include, but is not limited to, the following diagnostic tests and procedures necessary to determine Infertility:

- hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sons-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound;

Infertility Covered Services are limited to Members between the ages of 21 through 44, and must be part of a Physician's overall plan of care.

Coverage for hospital, surgical and medical care for the diagnosis and treatment of correctable medical conditions that result in Infertility are not subject to the age and treatment limitations stated above. Coverage is not excluded for the diagnosis and treatment of a correctable medical condition covered under this Group Policy solely because the medical condition results in Infertility.

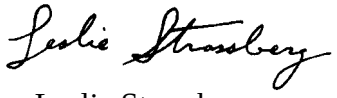
Infertility Covered Services are subject to applicable co-payments, coinsurance and deductibles that are consistent with those established for other benefits under this Group Policy.

INFERTILITY DIAGNOSIS AND TREATMENT SERVICES AMENDMENT- cont.

If Infertility Covered Service are denied on the basis that the service or supply is not Medically Necessary and Appropriate, the Member or his or her representative may appeal that decision to an External Appeal Agent, an entity certified by the state of new York to conduct such appeals.

Infertility Covered Services do not include the diagnosis and treatment of Infertility in connection with (a) in vitro fertilization, GIFT, ZIFT, (b) the reversal of elective sterilization, (c) sex change procedures, (d) cloning or (e) experimental medical and surgical procedures.

Signed for Health Insurance Plan Insurance Company of New York.



Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All other term, conditions, limitations and exclusions of the Policy/Certificate shall remain unchanged. This amendment is effective for a Policy/Certificate issued or renewed on or after September 1, 2002.

HIP®
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HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET– NEW YORK, NEW YORK 10041

AMENDMENT TO BE ATTACHED TO YOUR HIPIC POLICY/CERTIFICATE OF COVERAGE ISSUED BY HIPIC.

PRESCRIPTION DRUG AMENDMENT

This Amendment provides the Prescription Drug benefits described below:

Definitions.

A. **"Brand Name Drug"** is a drug, which is approved by the Food and Drug Administration ("FDA") and protected by the trademark registration of the pharmaceutical company, which produces it.

B. **"Drug Formulary"** is a list of items, which may be covered if dispensed by Participating Pharmacies to HIPIC members. This list consists mainly of Prescription Drugs but also includes some non-prescription drugs and nutritional supplements for the therapeutic treatment of phenylkenoturia and related disorders. This list is prepared by HIPIC and periodically reviewed and modified.

C. **"Generic Drug"** is a drug that has been approved by the FDA as therapeutically equivalent to a brand-name drug.

D**. "HIPIC Participating Pharmacy"** is a pharmacy which is owned and operated by HIPIC or one which has an agreement with HIPIC to provide covered Prescription Drugs and other prescribed items to HIPIC members.

E**. "HIPIC Mail Order Service"** means a vendor which has an agreement with HIPIC to provide covered Prescription Drugs to HIPIC Members via a mail order process.

F. **"Infertility Prescription Drug"** is a drug approved by the FDA for use in the diagnosis and treatment of Infertility. Infertility Prescription Drug coverage is available to Members ages 21 through 44.

G. **"Prescription Drug"** is a drug which has been approved for use by the FDA and which by law is required to bear the legend "Caution - Federal Law prohibits dispensing without prescription" (Legend); or is an enteral formula which is medically necessary and taken under written order from a physician for the treatment of specific diseases and distinguished from nutritional supplements taken electively; or is a modified solid food product which is medically necessary for the treatment of certain inherited diseases of amino acid and organic acid metabolism.

Prescription drugs that are not approved by the FDA for treatment of cancer may also be covered if the drug has been recognized as treatment by the following medical references for the type of cancer for which the drug has been prescribed: The American Medical Drug Evaluations, the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia Drug Information or, when recommended by a review article or editorial commentary in a major peer reviewed professional journal.

H. **"Specialty Pharmacy Drugs"** are pharmaceutical agents that include injectables and oral drugs available through the Specialty Pharmacy Program. Specialty Pharmacy Drugs tend to be more complex to administer and monitor in comparison to traditional drugs. Key characteristics of specialty drugs include, but are not limited to, the following:

i. Requires frequent dosage adjustments.
ii. Causes more severe side effects.
iii. Involves special storage, handling and/or administration.
iv. Entails a narrow therapeutic range.
v. Necessitates periodic lab or diagnostic testing.

Specialty Pharmacy Drugs are comprised of the following general classes of drugs:

i. Hepatitis C Agents
ii. Multiple Sclerosis Agents
iii. Rheumatoid Arthritis Agents
iv. Plaque Psoriasis Agents
v. Infertility Agents
vi. Growth Hormone
vii. Injectable Contraceptive, Progestin
viii HIV Fusion Inhibitor
ix. Calcium Regulator, Self Injectable

These categories are prepared by HIPIC and may be semi-annually reviewed and modified.

I. **"Specialty Pharmacy Program"** is a program that manages the benefits available for Specialty Pharmacy Drugs and provides the services listed below:

i. Educational Materials, support and/or home instruction information.
ii. Ancillary Supplies such as syringes and needles at no additional cost.
iii. Comprehensive Coordination of Care including refill reminders and interaction with your physician regarding your medication(s).

J. **"Specialty Pharmacy Program Provider"** is a designated vendor who has an agreement with HIPIC to dispense covered injectable and oral drugs to HIPIC members through the specified Specialty Pharmacy Program Provider mail order service.

PRESCRIPTION DRUG AMENDMENT-cont.

Benefits.

A. The item may be prescribed by a HIPIC Participating or Non-Participating Provider and must be filled at a HIPIC Participating Pharmacy or via HIPIC's Mail Order Service. In no event shall the copay indicated below, if any, exceed the cost of the item prescribed. Specialty Pharmacy Drugs must be dispensed by a Specialty Pharmacy Program Provider and are not available at a HIPIC Participating Pharmacy or through the HIPIC Mail Order Service. Specialty Pharmacy Drugs require a "Certificate of Medical Necessity" ("CMN") and/or prior approval, in which the prescribing physician must seek and obtain prior approval from HIPIC's Pharmacy Services.

B. **Formulary Benefit**
The prescribed item must be on the Drug Formulary. If the item needs to be compounded, it must contain Prescription Drugs listed in the Drug Formulary.

Copay Benefit

The Member pays the HIPIC Participating Pharmacy $7 for every 30-day supply (or less) of a Generic Drug, and $30 for every 30 days supply (or less) of the Brand Name Drug. If HIPIC's mail order service is used, these copays are reduced by 50%.

The Member pays the Specialty Pharmacy Program Provider $7 for every 30-day supply (or less) of a Generic Drug, and $30 for every 30 days supply (or less) of the Brand Name Drug.

C. **Non-Formulary Benefit**
The prescribed item is not required to be on the Drug Formulary. If the item is not on the Drug Formulary the copay is as follows:

Copay Benefit

The Member pays the HIPIC Participating Pharmacy $50 for every 30-day supply.

The Member pays the Specialty Pharmacy Program Provider $50 for every 30-day supply.

PRESCRIPTION DRUG AMENDMENT-cont.

Exclusions.

A. Experimental drugs not approved by the FDA, drugs with no approved FDA indications and DESI (Drug Efficacy Study Implementation) products, i.e., those rated by the FDA as not proven safe and effective. Except, however, that coverage will be provided if an External Appeal Agent approves coverage of an experimental or investigational drug. There is no coverage for experimental or investigational Infertility Prescription Drugs.

B. Prescription Drugs for the treatment of obesity, unless Medically Necessary and Appropriate.

C. Non-prescription, over the counter diet pills and aids.

D. Dietary supplements, unless Medically Necessary and Appropriate.

E. Vitamins, except Legend pre-natal vitamins and Legend vitamins that are medically necessary for the treatment of renal disease, hypoparathyroidism or other covered conditions with prior authorization by HIPIC. Over the counter vitamins such as iron, B12 and folic acid are not covered.

F. Drugs for the treatment of baldness.

G. Drugs for the diagnosis and treatment of Infertility in connection with (a) in vitro fertilization, GIFT, ZIFT, (b) the reversal of elective sterilization, (c) sex change procedures, (d) cloning or (e) experimental medical and surgical procedures.

H. Pre-filled syringe kits, syringes and needles, except insulin syringes.

I. Non Prescription Drugs, including biologicals and injectable drugs except insulin, Epi-Pen, Epi-Pen, Jr. and self-administered injectables.

J. Pharmaceuticals whose primary use is for cosmetic purposes, unless Medically Necessary and Appropriate for the treatment of a physical condition.

K. Smoking cessation products, unless Medically Necessary and Appropriate.

L. Methadone maintenance medications.

M. Lost, stolen or destroyed medication(s).

N. Devices and appliances, except when required by State or Federal Law.

PRESCRIPTION DRUG AMENDMENT-cont.

Limitations

A. Any prescription which the pharmacist, in the exercise of his/her professional judgment, decides should not be filled. In such a case, the pharmacist will call the practitioner who wrote the prescription to determine the appropriate course of action.

B. More than 11 refills per prescription or refills dispensed more than 12 months after the original date of the prescription.

Signed for HIP Insurance Company of New York

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All other terms, conditions, limitations and exclusions of the Policy/Certificate shall remain unchanged. This amendment is effective for a Policy/Certificate issued or renewed on or after September 1, 2002.

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK CERTIFICATE OF COVERAGE

RIDER TO BE ATTACHED TO YOUR CERTIFICATE OF COVERAGE ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK.

The following will be covered under this Rider:

OPTICAL BENEFITS

- One pair of corrective eyeglasses every twenty-four (24) months prescribed by a HIP Participating Physician and filled by a HIP Participating Optical Provider;
- The Member must choose the frames and lenses from a select group at any HIP Participating Provider. If the Member selects any other frames or lenses, he or she will pay the difference between the retail price of the item selected and the retail price of the item covered.
- Copayment: $45

Signed for Health Insurance Plan of Greater New York and HIP Insurance Company of New York

Daniel T. McGowan
President

Leslie Strassberg
President

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK 7 WEST 34TH STREET – NEW YORK, NEW YORK 10001

ADMENDMENT TO BE ATTACHED TO YOUR GROUP CERTIFICATE ISSUED BY HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK.

This amendment becomes effective May 1, 2003.

This amendment revises the Certificate by adding the following definition and prior approval requirements.

Definition.

"**Prior Approval"** means a system whereby a provider must receive approval from HIP Care Management Program except, if services are obtained from an out-of-network provider, the member must receive approval before receiving certain health care services.

Prior Approval Requirements

Prior approval must be obtained from the HIPIC Care Management Program (CMP) for the services indicated below:

- Inpatient non emergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient surgery for procedures and treatment in a facility or doctor's office.
- Inpatient treatment of Mental Illness and Chemical Abuse and Dependence, Detoxification treatment of Chemical Abuse and Dependence, and Rehabilitation treatment of Chemical Abuse and Dependence.
- Outpatient treatment of Mental Illness and Chemical Abuse and Dependence and ambulatory Detoxification treatment of Chemical Abuse and Dependence.
- Non emergent transportation.
- Home Health Care.

- Hospice Care.
- Services obtained by Non-Participating Providers with specialty expertise.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient Diagnostic Radiology Services.

Failure to comply will result in a 50% reduction of all related benefits. Additionally, HIPIC does not pay benefits for any charges incurred which HIPIC determines not to be Medically Necessary and Appropriate.

Signed for Health Insurance Plan of Greater New York and HIP Insurance Company of New York

Daniel T. McGowan
President

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All the terms, conditions, limitations and exclusions of the Group Certificate shall remain unchanged.

HIP
HEALTH PLAN OF NEW YORK

HIP
INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HIP INSURANCE COMPANY OF NEW YORK
55 WATER STREET, NEW YORK, NEW YORK 10041

RIDER TO BE ATTACHED TO YOUR HIP CONTRACT/POLICY/CERTIFICATE OF COVERAGE ISSUED BY THE HEALTH INSURANCE PLAN OF GREATER NEW YORK AND HIP INSURANCE COMPANY OF NEW YORK

SUICIDE EXCLUSION RIDER

This Rider amends Your CERTIFICATE OF COVERAGE as follows:

- The exclusionary provision under the section entitled **"EXCLUSIONS AND LIMITATIONS"**, which states "Services required for a condition arising out of participation in a felony, riot or insurrection, suicide or intentionally self-inflicted injury. However, benefits are available for mental health services in connection with attempted suicide" is deleted in its entirety and replaced with the following:
  - "Services required for a condition arising out of participation in a felony, riot or insurrection".

All the terms, conditions, limitations and exclusions of the Certificate of Coverage apply to the benefits provided by this Rider.

Signed for Health Insurance Plan of Greater New York

Daniel T. McGowan
President and Chief Operating Officer

HIP Insurance Company of New York

Leslie Strassberg
President

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF NEW YORK
HEALTH INSURANCE PLAN INSURANCE COMPANY OF NEW YORK
7 WEST 34TH STREET - NEW YORK, NEW YORK 10001

ADMENDMENT TO BE ATTACHED TO YOUR GROUP POS CERTIFICATE OF COVERAGE ISSUED BY THE HEALTH INSURANCE PLAN INSURANCE COMPANY OF NEW YORK.

WOMEN'S HEALTH & WELLNESS AMENDMENT

The HIP PRIME POS Certificate is amended as follows:

1. The "Preventive Health Services" provision under the MEDICAL SERVICES section of the Certificate is amended by deleting all the language pertaining to mammograms and replacing such language with the following:

   Mammography Screening. HIP will pay for services for mammography screening as follows:

   - Upon recommendation of the Member's Physician, a mammogram at any age for a woman with a prior history of breast cancer or who has a first-degree relative who has a prior history of breast cancer. A first-degree relative is a parent, sibling or child.
   - One (1) baseline mammogram for any woman between thirty-five (35) and thirty-nine (39) years of age, inclusive.
   - One (1) mammogram every Calendar Year if the Member is forty (40) years of age or older.

2. The "Preventive Health Services" provision under the MEDICAL SERVICES section of the Certificate is amended by adding the following provision.

   For the purposes of this benefit "mammography screening" is the imaging examination of the breast using dedicated equipment for screening and diagnosing breast disease.

   Bone Mineral Density Screening. HIP will pay for services for bone mineral density measurements or tests in accordance with the standards and criteria established by the Federal Medicare program and the National Institutes of Health for the Detection of Osteoporosis. Members eligible to receive such benefits include, at a minimum:

   - a Member who has been previously diagnosed as having osteoporosis, or having a family history of osteoporosis; or,
   - a Member with symptoms or conditions that indicate the presence or risk of osteoporosis; or,

WOMEN'S HEALTH & WELLNESS AMENDMENT

- a Member on a prescribed drug regimen that poses a significant risk of osteoporosis; or,
- a Member with lifestyle factors to a degree that poses a significant risk of osteoporosis; or,
- a Member of the age, gender or physiological characteristics that poses a significant risk of osteoporosis.

3. The "Family Planning Services" provision under the MEDICAL SERVICES section of the Certificate is amended by deleting all the language pertaining to contraceptive drugs and devices.

Signed for Health Insurance Plan of Greater New York

Daniel T. McGowan
President

Health Insurance Plan Insurance Company of New York.

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

The Certificate provides that all of its provisions and conditions not inconsistent with the provisions and conditions referred to herein shall apply to this coverage. All other term, conditions, limitations and exclusions of the Certificate apply. This amendment is effective for a Certificate issued or renewed on or after January 1, 2003.

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK
AND HIP INSURANCE COMPANY OF NEW YORK
7 WEST 34TH STREET - NEW YORK, NEW YORK 10001

RIDER TO BE ATTACHED TO YOUR CERTIFICATE OF COVERAGE ISSUED
BY HEALTH INSURANCE PLAN OF GREATER NEW YORK
AND HIP INSURANCE COMPANY OF NEW YORK.

PROSTATE CANCER SCREENING AMENDMENT

This Rider provides benefits as follows:

Subject to the Schedule of Benefits, coverage is provided for diagnostic screening for prostate cancer when authorized by a Physician, Provider or Other Health Care Professional. Coverage for prostate cancer screening includes:

- Standard diagnostic testing of prostate cancer, including but not limited to a digital rectal examination and a prostate-specific antigen testing for men of any age with a prior history of prostate cancer.

- An annual standard diagnostic examination including but not limited to a digital rectal examination and a prostate-specific antigen testing for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risks.

Signed for Health Insurance Plan of Greater New York and HIP Insurance Company of New York

Daniel T. McGowan
President

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

All other terms, conditions, limitations and exclusions of the Certificate shall remain unchanged.

HEALTH PLAN OF NEW YORK

INSURANCE COMPANY OF NY

HEALTH INSURANCE PLAN OF GREATER NEW YORK
HEALTH INSURANCE PLAN INSURANCE COMPANYOF NEW YORK
7 WEST 34TH STREET, NEW YORK, NEW YORK 10001

AMENDMENT TO BE ATTACHED TO YOUR GROUP POS
POLICY/CERTIFICATE OF COVERAGE ISSUED BY
THE HEALTH INSURANCE PLAN OF GREATER NEW YORK
and HEALTH INSURANCE PLAN INSURANCE COMPANY OF NEW YORK.

PRIME POS AMENDMENT RIDER

The HIPIC PRIME POS Policy/Certificate is amended as follows:

1. The first paragraph of the **"Preadmission Testing"** provision under the **HOSPITAL SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

   Preadmission Testing. HIPIC pays for preadmission testing performed in a Hospital and in an outpatient facility of a Hospital, as planned preliminary to ambulatory surgery or an inpatient admission of a Member for surgery in the same Hospital, provided that:

2. The first paragraph of the **"Organ Transplants"** provision under the **HOSPITAL SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

   Organ Transplants. Coverage is provided for organ transplants that are determined by HIPIC, in its sole discretion, to be non-Experimental or non-Investigational. If HIPIC has denied coverage on the basis that the service is an Experimental or Investigational treatment, the Member or his or her representative may appeal that decision in accordance with the Grievance and Appeals procedures as stated in the member handbook. Covered transplants include but are not limited to: kidney, corneal, liver, heart and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. All covered transplants must be prescribed by the Member's PCP or other Participating Physician, and approved in advance by HIPIC MAP. Additionally, all transplants must be performed at Hospitals that HIPIC has specifically approved and designated to perform these procedures.

3. The **"End of Life Care"** provision is added to the **HOSPICE CARE SERVICES** section of the Policy/Certificate.

   Covered End of Life Care. HIPIC pays for acute care services for a Member diagnosed with advanced cancer, with no hope of reversal of the primary disease, and with fewer than sixty days to live. The services must be received at an appropriately licensed acute care facility specializing in the treatment of the terminally ill.

PRIME POS AMENDMENT RIDER, cont.

The Member's attending health care practitioner, in consultation with the medical director of the facility must determine that the Member's care would be appropriately provided by such a facility.

4. The **"Diabetic Equipment, Supplies and Education"** provision under the **MEDICAL SERVICES** section of the Policy/Certificate is amended by adding the following:

   - Additional Medically Necessary equipment and supplies, as may be required by the Commissioner of the Department of Health.

5. The **"Inpatient Treatment of Mental Illness"** provision under the **HOSPITAL SERVICES** section of the Policy/Certificate is amended by adding "a certified social worker" as a covered provider.

6. The **"Inpatient Alcohol and Substance Abuse Detoxification"** provision under the **HOSPITAL SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

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

7. The **"Inpatient Rehabilitation Treatment of Alcohol and Substance Abuse"** provision under the **HOSPITAL SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

   Inpatient Rehabilitation Treatment of Chemical Abuse and Dependence. If indicated on the attached Schedule of Benefits, benefits are available for a limited number of days for inpatient rehabilitation treatment of chemical abuse and dependence.

8. The **"OUTPATIENT REHABILITATION TREATMENT OF ALCOHOLISM AND SUBSTANCE ABUSE"** section of the Policy/Certificate is deleted and replaced with the following:

   OUTPATIENT REHABILITATION TREATMENT OF CHEMICAL ABUSE AND DEPENDENCE

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

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

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

9. The **HOME HEALTH CARE SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

Covered Services. When approved in advance by the HIPIC Care Management Program, HIPIC will pay Medically Necessary and Appropriate Home Health Care Services for a Member who requires a level of Skilled Care that can be provided in lieu of care in a Hospital or Skilled Nursing Facility. Coverage is provided only to the extent determined by HIPIC to be in accordance with the standards of generally accepted medical practice. Home Health Care services shall be subject to the applicable Copayment and number of visits as indicated on the attached Schedule of Benefits.

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

Home Health Care Services include visits by professional nurses and other licensed health professionals in the Member's home. Each visit by a member of a home care team is considered as one home care visit. Four (4) hours of home health aide services are considered one home care visit.

Home Health Care must be provided by a duly certified or licensed agency that provides one or more of the following services:

- Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).
- Part-time or intermittent home nursing aide services that consist primarily of caring for the patient.
- Physical, occupational or speech therapy, if provided by the home health service or agency.
- Medical supplies, drugs and medications prescribed by a Physician.
- Laboratory services by or on behalf of a certified home health agency to the extent that such services are covered under this Certificate if the Member had been hospitalized or confined in a Skilled Nursing Facility.

PRIME POS AMENDMENT RIDER, cont.

Coverage is not provided for care which HIPIC, in its sole judgement, determines to be primarily custodial. Custodial care is care that does not require the continuing attention of trained medical personnel. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care are:

- Assistance in meeting activities of daily living, such as transferring, eating, dressing, bathing, toileting and other related activities.

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

10. The **"Who is Covered"** provisions under the **ELIGIBILITY** section of the Policy/Certificate are amended as follows:

    Subsection B. is deleted and replaced with the following provision which adds stepchildren as eligible dependents.

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

    Subsection D. is deleted and replaced with the following provision that amends full-time student eligibility.

    D. Unmarried children and stepchildren of the Member who are under the age limit shown on the attached Schedule of Benefits who are enrolled as a full-time student at accredited institutions of learning, and who are dependent on you and/or your spouse for support. Coverage of such Full Time Student will terminate as of the end of the month in which the child no longer meets all of these conditions, or the date of marriage, whichever occurs first, except that any Full Time Student on medical leave of absence shall have the opportunity for continuing coverage under a parent or guardian's policy for at least one year beyond the last day of attendance in school. Continuing coverage for medical leaves of absence shall be granted only if the student has presented to HIPIC documentation of the illness requiring a leave of absence and certification from a medical practitioner licensed to practice in the State of New York as to the medical necessity of a medical leave of absence from school. In no event shall HIPIC provide coverage for benefits beyond the age limit specified in the Schedule of Benefits for Full Time Students.

PRIME POS AMENDMENT RIDER, cont.

11. The **"EXCLUSIONS AND LIMITATIONS"** section of the Policy/Certificate is amended as follows:

    The **Blood** exclusion is deleted and replaced with the following:

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

    The **Dental Care** exclusion is deleted and replaced with the following:

    Dental Care . Benefits are not available for dental care. However, treatment required in connection with an accidental injury to sound natural teeth if the service is provided within twelve (12) months after the accident, and treatment due to congenital disease or anomaly that is present from birth is covered.

    The **Durable Medical Equipment** exclusion is deleted and replaced with the following:

    Durable Medical Equipment . Durable medical equipment, including, but not limited to wheelchairs, hospital beds and prosthetic devices, except prosthetic devices following a mastectomy.

    The **Pharmacy** exclusion is deleted and replaced with the following:

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

    The following services, treatments and benefits are also excluded under this Policy/Certificate subsection is amended and revised as follows:

    The exclusion pertaining to gender transformation is deleted and replaced with the following:

    - Surgery or any related care (or after care) in connection with gender transformation, except when medically necessary.

12. The private room exclusion in **Exclusions and Limitations** subsection under the **HOSPITAL SERVICES** section of the Policy/Certificate is deleted and replaced with the following:

    - Private room, except when Medically Necessary. If a Member occupies a private room, he or she will have to pay the difference between the Hospital's charges for a private room and the Hospital's most common charge for semi-private accommodations.

PRIME POS AMENDMENT RIDER, cont.

13. The **"Subrogation and Right of Recovery"** provision under the **COORDINATION OF BENEFITS** section of the Policy/Certificate is deleted and replaced with the following:

    Subrogation and Right of Recovery. 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 HIPIC pays benefits as a result of that injury or illness, HIPIC will be subrogated and succeed to the right of recovery against the party responsible for the Member's illness or injury to the extent of the benefits HIPIC has paid. This means that HIPIC has the right independent of the Member to proceed against the party responsible for the Member's injury or illness to recover the benefits HIPIC has paid.

    Duty to Cooperate with HIPIC . Possible Penalties for Failure to Cooperate. Under certain circumstances, HIPIC is also entitled to be reimbursed for the benefits HIPIC has paid from a settlement or a judgment the Member receives from the party responsible for their illness or injury. This and other penalties which apply under certain circumstances are noted below. Those circumstances are:

    1. The settlement or judgment the Member receives from the party responsible for their illness or injury specifically identifies or allocates monetary sums directly attributable to expenses for which HIPIC has paid benefits; or
    2. The Member fails to cooperate with HIPIC in proceeding against the party responsible for their illness or injury to recover the benefits HIPIC has paid. HIPIC will pay all expenses associated with a legal action instituted on HIPIC's initiative.

    The Member will be responsible to repay to HIPIC the cost of the benefits and services HIPIC has paid for failing to cooperate with HIPIC as indicated above.

14. The **"Medicare Eligibility"** provision under the **COORDINATION OF BENEFITS** section of the Policy/Certificate is amended by adding the following:

    - Members who are eligible for Medicare due to End Stage Renal Disease (ESRD) will receive benefits under this Group Policy as primary during the thirty (30) month period which begins with the first month in which the Member becomes eligible for Part A of Medicare, or if earlier, the first month in which the Member would have been eligible for Part A of Medicare had the member filed an application for such Medicare benefits. At the end of the thirty (30) month period benefits under this Group Policy will be paid secondary to Medicare.

PRIME POS AMENDMENT RIDER, cont.

15. The **"Member Termination"** provision under the **TERMINATION OF COVERAGE** section of the Policy/Certificate is amended by adding the following:

    - Any reason approved by the Superintendent of Insurance and authorized by Health Insurance Portability Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

16. The **"Extension of Coverage for Handicapped Children"** provision under the **EXTENSION AND CONTINUATION OF COVERAGE** section of the Policy/Certificate is amended by adding the following:

    - Chiefly dependent upon the Subscriber for support and maintenance.

17. The **"Continuation of Coverage"** provision under the **EXTENSION AND CONTINUATION OF COVERAGE** section of the Policy/Certificate is deleted and replaced with the following:

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

    A. If the Subscriber loses coverage due to termination of employment or reduction of hours, the Subscriber and his or her dependents may elect continuation coverage for 18 months. If the Subscriber becomes eligible for Medicare during these 18 months, his or her covered dependents may extend the coverage up to 36 months. If the Subscriber is disabled on the date of loss of group coverage, or becomes disabled within the first 60 days of coverage under COBRA continuation, he or she may elect to extend COBRA continuation for an additional 11 months for a total continuation period of 29 months.

    B. If the Subscriber becomes eligible for Medicare, dies, divorces or legally separates from a spouse covered under this Policy/Certificate, the former spouse and the dependent child(ren) may elect continuation coverage for 36 months.

    C. If the Subscribers dependent child(ren) covered under this Policy/Certificate are no longer eligible for this coverage, the dependent child(ren) may elect continuation coverage for 36 months.

    D. HIPIC or the Group will send eligible Members an election notice when group coverage terminates. Eligible Members have sixty (60) days to make the election and forty-five (45) days from the date of election to pay the first premium. The Member must then remit future payments in a timely manner.

PRIME POS AMENDMENT RIDER, cont.

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

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

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

18. The **"Guaranteed Renewability of Coverage"** provision under the **ADDITIONAL GROUP PROVISIONS** section of the Policy/Certificate is amended by adding the following:

    7. Any reason approved by the Superintendent of Insurance and authorized by Health Insurance Portability Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

Signed for Health Insurance Plan of Greater New York

Daniel T. McGowan
President

Health Insurance Plan Insurance Company of New York.

Leslie Strassberg
President

APPLICABILITY OF OTHER PROVISIONS

The Policy/Certificate provides that all of its provisions and conditions not inconsistent with the provisions and conditions referred to herein shall apply to this coverage. All other term, conditions, limitations and exclusions of the Policy/Certificate apply.