**SECTION I**

**Definitions**

*{Drafting Note: Use for individual, small group, and large group coverage.}*

Defined terms will appear capitalized throughout this [Certificate; Contract; Policy].

**Acute:** The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

**Allowed Amount:** The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this [Certificate; Contract; Policy] for a description of how the Allowed Amount is calculated. [If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider’s charge, in addition to any Cost-Sharing requirements.]

*{Drafting Note: Use the bracketed language for plans with an out-of-network option.}*

**Ambulatory Surgical Center:** A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Appeal:** A request for Us to review a Utilization Review decision or a Grievance again.

**Balance Billing:** When a Non-Participating Provider bills You for the difference between the Non-Participating Provider’s charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

[**Certificate; Contract; Policy**]**:** This [Certificate; Contract; Policy] issued by [insert health plan name], including the Schedule of Benefits and any attached riders.

*{Drafting Note: Insert “certificate” for group coverage. Insert “contract” for individual coverage issued by HMOs or Article 43 corporations. Insert “policy” for individual commercial coverage.}*

**Child, Children:** The Subscriber’s Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this [Certificate; Contract; Policy].

**Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

**Copayment:** A fixed amount You paydirectly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

**Cost-Sharing:** Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

[**Cost-Sharing Reductions:** Discounts that lower cost-sharing for certain services covered by individual coverage purchased through the NYSOH. You may get a discount if Your income is below a certain level and You choose a silver level plan. If You are a member of a federally recognized tribe, You can qualify for Cost-Sharing Reductions on certain services covered by individual coverage purchased through the NYSOH at any metal level and You may qualify for additional Cost-Sharing Reductions depending upon Your income.]

*{Drafting Note: Insert for individual coverage.}*

**Cover, Covered or Covered Services:** The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this [Certificate; Contract; Policy].

**Deductible:** The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**Dependents:** The Subscriber’s Spouse and Children. [Additional Dependents are also described in the Who is Covered section of this [Certificate; Contract; Policy].]

*{Drafting Note: Insert the bracketed language above if the additional dependents paragraph is included in the Who is Covered section of this certificate, contract, or policy.}*

**Durable Medical Equipment (“DME”):**  Equipment which is:

* Designed and intended for repeated use;
* Primarily and customarily used to serve a medical purpose;
* Generally not useful to a person in the absence of disease or injury; and
* Appropriate for use in the home.

**Emergency Condition:** A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

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

**Emergency Department Care:** Emergency Services You get in a Hospital emergency department.

**Emergency Services:** A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

**Exclusions:**  Health care services that We do not pay for or Cover.

**External Appeal Agent:** An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

**Facility:** A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28(or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

**Grievance:** A complaint that You communicate to Us that does not involve a Utilization Review determination.

[**Group:** The employer or party that has entered into an agreement with Us as a [contractholder; policyholder].]

*{Drafting Note: Insert for group coverage.}*

**Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

**Health Care Professional:** An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this [Certificate; Contract; Policy].

**Home Health Agency:** An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

**Hospice Care:** Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

**Hospital:** A short term, acute, general Hospital, which:

* Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
* Has organized departments of medicine and major surgery;
* Has a requirement that every patient must be under the care of a Physician or dentist;
* Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
* If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
* Is duly licensed by the agency responsible for licensing such Hospitals; and
* Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

**Hospitalization:** Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**Hospital Outpatient Care:** Care in a Hospital that usually doesn’t require an overnight stay.

[**In-Network Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider [or to a Preferred Provider]. The amount can vary by the type of Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use coinsurance for in-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**In-Network Copayment:** A fixed amount You pay directly to a Participating Provider [or to a Preferred Provider] for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use copayments for in-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**In-Network Cost-Sharing**: Amounts You must pay to a Participating Provider [or to a Preferred Provider] for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.]

*{Drafting Note: Use for plans with an out-of-network option. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**In-Network Deductible:**  The amount You owe before We begin to pay for Covered Services received from Participating Providers [or Preferred Providers]. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use deductibles for in-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**In-Network Out-of-Pocket Limit:**  The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers [or Preferred Providers]. This limit never includes Your Premium or services We do not Cover.]

*{Drafting Note: Use for plans with a separate out-of-network out-of-pocket limit. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

**Medically Necessary:** See the How Your Coverage Works section of this [Certificate; Contract; Policy] for the definition.

**Medicare:** Title XVIII of the Social Security Act, as amended.

**Member:** The Subscriberor a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, “Member” also means the Member’s designee.

**Network:** The Providers We have contracted with to provide health care services to You.

[**New York State of Health (“NYSOH”):** The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace for health insurance where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus, and the Essential Plan.]

*{Drafting Note: Insert for plans issued inside the NYSOH or individual coverage offered outside the NYSOH.}*

[**Non-Participating Provider:**  A Provider who doesn’t have a contract with Us [or another XXX plan] to provide health care services to You. [You will pay more to see a Non-Participating Provider.] [The services of Non-Participating Providers are Covered only for Emergency Services [, Urgent Care] or when authorized by Us.]]

*{Drafting Note: Insert the applicable bracketed non-participating provider sentence, depending on whether the plan provides out-of-network coverage. Insert the “or another plan” language and the name of the plan if you have affiliated arrangements with other plans. Omit for coverage that does not have a provider network or is not sold with a network product.}*

[**Out-of-Network Coinsurance:** Yourshare of the costs of aCovered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use coinsurance for out-of-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**Out-of-Network Copayment:** A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use copayments for out-of-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**Out-of-Network Cost-Sharing**: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.]

*{Drafting Note: Use for plans with an out-of-network option. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**Out-of-Network Deductible:** The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.]

*{Drafting Note: Use for plans with an out-of-network option that use deductibles for out-of-network care. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

[**Out-of-Network Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.]

*{Drafting Note: Use for plans with a separate out-of-network out-of-pocket limit. Omit for all other coverage, such as coverage that does not have an out-of-network option or coverage that does not have a provider network.}*

**Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

[**Participating Provider:** A Provider who has a contract with Us [or another XXX plan] to provide health care services to You. A list of Participating Providers and their locations is available on Our website [at XXX] or upon Your request to Us. The list will be revised from time to time by Us. [You will pay higher Cost-Sharing to see a Participating Provider as compared to a Preferred Provider[, but less than if You received Covered Services from a Non-Participating Provider].]]

*{Drafting Note: Insert the “or another plan” language and the name of the plan if you have affiliated arrangements with other plans. Insert the last sentence for tiered networks. Insert bracketed language in the last sentence if the plan offers out-of-network coverage. Omit for coverage that does not have a provider network or is not sold with a network product.}*

**Physician or Physician Services:** Health care services alicensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan Year:** [The 12-month period beginning on the effective date of the [Certificate; Contract; Policy] or any anniversary date thereafter, during which the [Certificate; Contract; Policy] is in effect.] [A calendar year ending on December 31 of each year.]

*{Drafting Note: Plans must use the first sentence for group coverage offered inside the NYSOH. Plans may use either sentence for group coverage offered outside the NYSOH. Plans must use the second sentence for individual coverage.}*

**Preauthorization**: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary.We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this [Certificate; Contract; Policy].

[**Preferred Provider:** A Provider who has a contract with Us to provide health care services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.]

*{Drafting Note: Use for plans with tiered networks.}*

**Premium:** The amount that must be paid for Your health insurance coverage.

[**Premium Tax Credits:** Financial help that lowers Your taxes to help You and Your family pay for private health insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower Your monthly Premium.]

*{Drafting Note: Insert for individual coverage.}*

**Prescription Drugs:** A medication, product or device that has been approved by the Food and Drug Administration (“FDA”) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill [and is on Our formulary]. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

*{Drafting Note: The bracketed language is optional.}*

**Primary Care Physician (“PCP”):** A participating [nurse practitioner] [or] [physician assistant] [or]] Physicianwho typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

**Provider:** A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this [Certificate; Contract; Policy] that is licensed, registered, certified or accredited as required by state law.

**Referral:** An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. [A Referral can be transmitted electronically[ or by Your Provider completing a paper Referral form].] [Except as provided in the Access to Care and Transitional Care section of this [Certificate; Contract; Policy] [or as otherwise authorized by Us,] a Referral will not be made to a Non-Participating Provider.] [A Referral is not required but is needed in order for You to pay the lower Cost-Sharing for certain services listed in the Schedule of Benefits section of this [Certificate; Contract; Policy].]

*{Drafting Note: Insert the second, third and fourth sentences as applicable. Insert the reference to paper referral forms if the plan accepts paper referrals. The bracketed “or as otherwise authorized by us” language is optional. Omit for coverage that does not have a provider network.}*

**Rehabilitation Services:** Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

**Schedule of Benefits:** The section of this [Certificate; Contract; Policy] that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, [Preauthorization requirements,] [Referral requirements,] and other limits on Covered Services.

**Service Area:** The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: [XXX]

*{Drafting Note: Insert list of counties in the plan’s service area.}*

**Skilled Nursing Facility:** An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

**Specialist:** A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Spouse:** The person to whom the Subscriber is legally married, including a same sex Spouse. [Spouse also includes a domestic partner].

*{Drafting Note: For group coverage, insert the domestic partner language if the group provides coverage for domestic partners in the base contract or policy. For individual coverage, insert the domestic partner language.}*

**Subscriber:** The person to whom this [Certificate; Contract; Policy] is issued.

**UCR** **(Usual, Customary and Reasonable):** The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

**Urgent Care:** Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a [participating] Physician's office or Urgent Care Center.

*{Drafting Note: Insert the bracketed language, as consistent with the urgent care benefit in the Emergency Services and Urgent Care section of this certificate; contract; policy.}*

**Urgent Care Center:** A licensed Facility [(other than a Hospital)] that provides Urgent Care.

*{Drafting Note: The bracketed language is optional.}*

**Us, We, Our:** [Insert health plan name] and anyone to whom We legally delegate performance, on Our behalf, under this [Certificate; Contract; Policy].

**Utilization Review:** The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

**You, Your:** The Member.