Atlantis Health Plan is now Easy Choice Health Plan of New York

1. Atlantis offers community rated group (2-50) plans to ***1099 employees*****.**
2. Easy Choice pays General Agents & Brokers commission on all business including (***direct individual, sole proprietors/1099, Healthy NY***).
3. Easy Choice is affiliated with AMG Medical Group that has offices in all five boroughs where members can receive Primary Care, GYN, urgent care and other necessary testing with ***no co-payment*****.**
4. Easy Choice has over ***33,000*** provider locations in its network and we continue to expand.
5. Easy Choice has ***no contribution requirements*** for any of its commercial plans.
6. Easy Choice has ***no participation requirements*** for its HMO products.
7. Easy Choice offers American Specialty Health's ***Healthyroads Prevention and Wellness Programs*** to all members (18 or over) at no cost.
8. Easy Choice offers online bill payment via the Easy Choice website.
9. All plans are Open Access (***No referrals needed***).
10. Easy Choice network includes recently contracted ***North Shore LIJ Hospital system***.

Easy Choice HEALTH PLAN (HMO)
Healthcare is a choice, make it Easy...

Through First National Administrators (2-50)

1. Group Agreement Form
2. First month's premium check made payable to: Easy Choice Health Plan (MUST BE COMPANY CHECK) from employer's business account
3. Employee enrollment forms for all eligible employees. Employee enrollment and Physician selection application MUST include SS#, DOB, complete address, date of marriage (if applicable) and physician selection.
4. Waiver Forms (if applicable)
5. Previous Insurance coverage form for all enrolling subscribers and dependents and copy of current carrier bill (if applicable)
6. Employees must live/work in one of the 5 Boroughs of NYC
7. Employees must be full time working at least 20 hours per week. Medicare recipients must also meet this requirement to be eligible.
8. Signed group agreement form
9. Record of Healthcare Coverage Form
10. Copy of quote
11. Broker agreement and paperwork if not appointed with Easy Choice
12. Groups enrolling 5 or more employees are allowed 2 plan options. Only one tier structure is allowed

Participation Requirements - HMO – 0% - no waivers required

Tax Documents - subject to change according to Easy Choice underwriters:

- Existing Corp – Most recent NYS-45
- Sole Proprietor – Business License, Form 1040/Schedule C and payroll
- "C" Corp – Articles of Incorporation, Form 1120 and payroll
- Church – Form 941 and payroll documents
- LLC – LLC agreement and the appropriate documentation noted above
- New Partnership – Partnership Agreement, Form 1065 and payroll
- Existing Partnership – K1,Form 1065, payroll documents and business license
- "S" Corp – Articles of Incorporation, Form 1120S and payroll documents
- 1099 Employees – must be submitted with either a Schedule C or 1099. Medicare recipients must also meet this requirement to be eligible.
- If business in existence less than 1 year and has not filed taxes-will accept Corporation or partnership papers and payroll documents

*Effective dates: 1st of the month only (unless a 15th of the month existing policy is in effect - NOTE – eligible employees of the group must reside in the Service Area or work in the area and receive all covered healthcare there

FNA
FIRST NATIONAL ADMINISTRATORS

FNA is not responsible for changes made by the carrier. All subject to carrier approval.

CASE INSTALLATION

1. **Small Group/Sole Proprietor Eligibility Sheet**

   A. The group must be actively in business with a street address in one of the five Boroughs: Bronx, Brooklyn, Manhattan, Queens, or Staten Island.

   B. Atlantis requires all enrolling subscribers to reside or work in the contracted area: Bronx, Brooklyn, Manhattan, Queens, or Staten Island

   C. Full-time is defined as actively at work at least 20 hours per week and a group must have at least one full-time employee to remain active. ***Sole Proprietor/1099 cases must be submitted with a Schedule C or 1099.***

   D. Owners, Partners and Officers must meet minimum hourly requirements. POS participation requirement is 50% participation after spousal waivers. There are no minimum requirements for HMO groups. Employees not electing coverage must submit a waiver form with case submission.

   E. Medicare recipients are eligible as long as they meet the criteria in #1C.

   F. Eligible dependents are defined as a legally married spouse or a legally dependent child up to the age of 19. Student rider up to age 23 is included in community rates if financially dependent and enrolled as a full-time student at an accredited educational institution. Riders to age 25 and age 29 are also available.

   G. The following are excluded from eligibility and coverage:

      a. Part-time employees (19 hours or less)

      b. Seasonal workers & temporary personnel

      c. Retirees

   H. ***Should Easy choice Health Plan of New York determine that group information is materially false, we reserve the right to terminate or deny coverage.***

2. **To enroll a new case, all completed documents must be submitted to Easy Choice Health Plan of New York no later than the fourth Monday of the month preceding the effective date.**

3. **Groups enrolling 5 or more employees are allowed 2 plan options. Only one tier structure is allowed.**

4. **All of the following information is required before processing**

A. Social Security Number

B. Date(s) of birth for all individuals applying

C. Complete address

D. Date of marriage (if applicable)

E. Physician selection

F. Employment effective (start) date

G. Dependent information

H. Employer, as well as Employee, signature

I. All small group businesses must supply the following tax documentation to Easy Choice Health Plan of New York:

a. Most recent Quarterly Wage & Tax Statement: NYS 45

b. If not required to file Wage & Tax Statement, one of the following is required:

i. Business Type Requirements

1. *If a "C" corporation*: Articles of incorporation, form 1120 (line 13 is wages) and payroll documents

2. *If a Church*: Form 941 (line 2 is wages) and payroll documents

3. *If an LLC*: LLC agreement and the appropriate documentation noted above

4. *If a Partnership*: K-1 or Form 1065 (line 9 is wages) and payroll documents and business license

5. *If an "S" corporation*: Articles of incorporation, form 1120S (line 8 is wages) and payroll documents

6. *If a Sole Proprietor*: Business license, form 1040/Schedule C (line 26 is wages) and payroll documents

c. If the business has been in existence less than 1 year and has not yet filed a Quarterly Wage and Tax Statement, Easy Choice Health Plan of New York will accept Corporation or Partnership papers and payroll documents.

Please note, incomplete applications will be returned and may affect the requested effective date.

5. Required Documentation for Case Installation

A. Group Agreement Form

B. Sales Submission Form

C. Check for 1st month premium from the employer's business account

D. Fully completed original employee enrollment forms and waiver forms (if applicable). Faxes or copies are not acceptable

E. Previous Insurance Coverage Form for all enrolling subscribers and dependents

F. Quarterly wage and tax statements (NYS 45) for small groups and Schedule C/1099 tax documents for Sole Proprietors/1099 employers (See chart below for tax)

G. Applicable Student Verification Form accompanied by original sealed document from educational institution

H. Previous Insurance Coverage Form and copy of current carrier bill on small groups (if applicable)

6. Enrollment & Waiting Periods

A. Groups are eligible for coverage on the 1st of the month only. We will accept 15th of the month effective dates only when an existing policy (effective 15th of the month) is in place.

B. Open enrollment will be held once a year on the group's anniversary or renewal date.

C. PLAN CHANGES. An official at the company should submit plan changes to Easy Choice Health Plan of New York no later than one month after initial enrollment. If no changes are made, the next period to change benefits will be during open enrollment.

D. Employee waiting periods can be 0, 30, 60 and/or 90 days but may not exceed 6 months.

E. New employees will be able to enroll in the plan on the first of the month following the plan's waiting period.

F. Employees who are terminated will be covered until the last day of the month in which the termination occurred. All terminations must be submitted either on a completed termination form or on company letterhead.

G. Those who decline coverage and subsequently wish to enroll without a qualifying event will only be eligible to enroll during the next annual open enrollment period.

***Qualifying Event*: An unexpected event that will terminate an employee's participation in another health plan. An example of a qualifying event is the loss of coverage through a spouse losing a job**

Easy Choice Health Plan of New York

Group Agreement Form

Group Administrator: _____

Group Name: _____

Group Number: _____

Effective Date: _____

Tax ID #: _____

In consideration of the payment of Premiums in accordance with the terms and provisions of this Group Agreement Form, Easy Choice Health Plan of New York ("Easy Choice") shall hereby arrange or pay for medical and hospital services in accordance with the terms and provisions of the Subscriber Contract for Subscribers and their Covered Dependents ("Members"). Terms not defined herein shall have the meaning set forth in the Subscriber Contract.

I. Effective Date and Term of Agreement:

This Agreement shall be effective on the _____ day of _____ at 12:00 a.m. Eastern Time and will remain in effect for a period of _____ consecutive Months, ending on the _____ day of _____ at 11:59 p.m. Eastern Time at which time coverage provided pursuant to the Subscriber Contract will be renewed automatically for one (1) year periods thereafter unless written notice of cancellation has been given by either party as set forth in Section XIII of this Agreement.

II. Coverage - Plan Design:

Group Size: O Only 1 Eligible Employee O 2+ Eligible Employees

Tier: O 2 O 3 O 4

Plan: O HMO O HMO-Low O POS O POS-Low

Co-Pay: O $10 O $10E O $15 O $15E
O $20 O $20E O $25/$40 O $25/$40E

Coinsurance: O 70% O 80%

Deductible: O $300/$750 O $1000/$2500
O $500/$1250 O $2000/$4000

Riders:

O A $10/20/30 O I $7/30/50/250 O 30+MH IP
O B $15/25/35 O O $0/20/30 O 30+MH/SA IP
O C $20/30/40 O P $0/30/50 O MHPAEA – 09
O D $10/15/30 O M-A 29 O SA – MHPAEA - 09
O E $15/20/35 O Vision-High O Timothy's Law
O F $20/25/40 O Vision-Low O PPACA – 1
O G $7/30/50 O 60 SNF O SIGN $0 - PPACA
O H $7/30/50/100 O 40+MH OP O Other: _____
O M Mandatory Generic $10 – PPACA

Hospital Co-Pay: O $0 O $250 O $500

III. Premium Rate Schedule:

Type of Coverage:	Total Monthly Premium
Single:	$ _____
Husband/Wife:	$ _____
Parent/Child(ren):	$ _____
Family:	$ _____

IV. Eligibility:

Eligible members must reside or live in the Service Area or work in the Area and receive all covered health care there. In addition, eligible subscribers and their eligible family members shall meet the eligibility criteria set forth in the Subscriber Contract. Coverage ends on the last day of the month premium covers.

*Waiting Period _____days/months from date of hire.
(Eligible the first of the month following waiting period).

Subscriber (employee) coverage ends on the last day of the month that employment ends.

Those groups subject to Patient Protection and Affordable Care Act **(**PPACA**)**, Family Members are spouse and dependent children until child reaches age 26. Coverage ends on the last day of the month in which the child's birthday occurs.

Eligibility will be restricted to an individual or small group where the individual or small group has had coverage terminated within the previous twelve (12) months for non-payment of premiums per Section 360.3(11) of Regulation 145.

V. Notice:

Any notice hereunder to be given to Group Administrator shall be addressed to:

Attn: _____

Address: _____

City, State, Zip: _____

Telephone#_____

Fax#_____

E-mail: _____

Any notice hereunder to be given to Easy Choice shall be addressed to:

Easy Choice Health Plan of New York
45 Broadway, Suite 300
New York, NY 10006

VI. Premium Due Date and Payments:

The first day of a month of coverage hereunder is the "Premium Due Date". The Group Administrator agrees to remit to Easy Choice on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Subscriber and Covered Dependent enrolled as of such date as determined by Easy Choice by reference to Easy Choice member records. If such Premium payment is not made in full by Group on or prior to the Premium Due Date, a thirty (30) day Grace Period shall be granted to Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then Easy Choice pursuant to Section XIII may terminate this Agreement.

If this Agreement is terminated for any reason, Group Administrator shall continue to be held liable for all Premium payments due and unpaid before termination, including, but not limited to, Premium payments for any time this Agreement is in force during the Grace Period. Notwithstanding any language to the contrary in this Agreement or the Subscriber Contract, Easy Choice shall have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made (except during any Grace Period). If Easy Choice does provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims shall not constitute a waiver of Easy Choice's rights to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. Premium Rate Changes:

The Premium Rate Schedule set forth on page one of this Agreement shall be valid only for the Initial Contract Period. If Easy Choice elects to offer coverage to the Group for any Subsequent Contract Period after the Initial Contract Period, Easy Choice may change the Premium Rate Schedule for any Subsequent Contract Period. Easy Choice will give Group at least forty-five (45) days advance notice of the Premium Rates for each Subsequent Contract Period. If Easy Choice fails to give Group such forty-five (45) days advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period shall remain in effect for a period of forty-five (45) days after the Group was notified by Easy Choice of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go in to effect. Under no circumstances shall Easy Choice's failure to provide forty-five (45) days advance notice of new Premium Rates obligate Easy Choice to continue coverage for the Group beyond the end of the Initial Contract Period or a Subsequent Contract Period as the case may be. At any time, with a forty-five (45) day notice, Easy Choice may change the premium schedule for any subsequent contract period when a change required by statute or regulation increases Easy Choice's risk under the agreement.

VIII. Member Effective Dates of Coverage:

Coverage of prospective Subscribers and Covered Dependents shall be subject to receipt by Easy Choice of Enrollment Form for each prospective Subscriber and Covered Dependent within thirty-one (31) days of each Subscriber or Covered Dependent becoming eligible for coverage under this Agreement, together with receipt of the monthly Premium for such Subscriber or Covered Dependent as applicable.

IX. Ineligible Members:

If, upon a Member becoming ineligible, Group Administrator fails to immediately notify Easy Choice of such Member's termination, and Group Administrator has made or continues to make the Premium payment specified herein for such Member, such Premium payment will only be credited by Easy Choice to Group back to the last day of the month immediately prior to the month in which such termination notice is received by Easy Choice, provided Easy Choice has not authorized or incurred claims for health services for such Members after such Member became ineligible, but before Easy Choice received a proper disenrollment notification from the Group with respect to such Member's termination.

X. Annual Renewal

The Group Administrator shall hold an annual renewal meeting at least once each year at which time the group and eligible members, as determined by this Agreement and the Subscriber Contract, may elect changes under this Agreement.

XI. Responsibilities of Group:

Group agrees to:

A. Offer coverage to eligible members and their family members, as described in Section IV above. It is understood that eligible members of a Group shall be free to choose either Easy Choice coverage or such other coverage as may be available through the Group during both the initial and subsequent Group Open Enrollment Periods. Every eligible member of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice, other than through differential payroll deductions as may be indicated by premium variations from insurer to insurer.
B. Offer each new member the opportunity to elect Easy Choice coverage as a procedure of employment when such person attains the status of an eligible member as provided in this Agreement.
C. Provide notification to each Member, within fifteen (15) days after termination of the Member's coverage, of the Member's right to convert to an Easy Choice individual direct payment contract, and the duration of such conversion coverage.
D. Furnish to Easy Choice, on a monthly basis on Easy Choice approved forms, such information as may reasonably by required by Easy Choice for the administration of Easy Choice's prepaid program and coverage provided hereunder, including any change in a Member's eligibility status. In addition, Easy Choice may, at reasonable times, examine the group's administrator's pertinent records with respect to eligibility and premium payments hereunder. Per the employee's signature on the Easy Choice enrollment application, the member agrees to allow the group to remit membership information to Easy Choice.
E. Comply with all policies and procedures established by Easy Choice in administering and interpreting this Agreement and communicated to Group Administrator by Easy Choice.
F. Furnish all Member enrollment and termination/change notification to Easy Choice solely on Easy Choice enrollment and termination forms within the time periods required by this Agreement.

XII. Termination:

A. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder may be terminated by Easy Choice:

1. In the event that the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the

terms of the contract as set forth in Section VI of this Agreement, or Easy Choice has not received timely premium payments.

2. In the event that the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract, upon not less than one month's prior written notice.

3. Upon discontinuance of this class of HMO contract upon not less than five (5) months' prior written notice. In exercising the option to discontinue coverage, Easy Choice shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and shall give the option to purchase all other individual health insurance coverage currently being offered by Easy Choice to applicants in that market.

4. Upon discontinuance of all hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small group market, or the large group market, or both markets, in this state. Written notice shall be given to the Superintendent and to each subscriber not less than one hundred eighty days (180) prior to the date of the expiration of such coverage. In the event of such a withdrawal, the Corporation must also provide the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by such withdrawal. In addition, Easy Choice may not provide for the issuance of any hospital, surgical or medical expense coverage in such market in this state during the five-year period beginning on the date of the discontinuance of the last health insurance coverage not so renewed.

5. The policyholder ceases to meet the requirements for a group under Section 4235 of the Insurance law, or a participating employer, labor union, association or other entity ceases membership or participation in the group to which this Agreement is issued. Termination shall be done uniformly without regard to any health status-related factor relating to any covered individual.

6. Pursuant to this network Plan, there is no longer any enrollee in connection with such Plan who lives, resides or works in the Easy Choice Service Area for which the corporation is authorized to do business.

7. Upon written notice, if the Group ceases to operate or relocates outside the Service Area; or

8. Such other reasons as the Superintendent may approve and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act, upon not less than one month's prior written notice.

B. Except as otherwise provided by applicable Law, this Agreement and the coverage provided hereunder **may be terminated by the Group upon one month's prior written notice of termination.**

XIII. Amendments:

Any amendments to this Agreement shall be in writing and must be approved and authorized by representatives of both the Group Administrator and Easy Choice. No other individual has the authority to modify this Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind Easy Choice by making any other commitment or representation.

Formal acceptance of an amendment to this agreement by the Group Administrator shall not be required: if the change has been negotiated by means of a request by the Group Administrator and agreed to by Easy Choice; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered-or of the federal government; or if the Group Administrator makes payment of any applicable Premium on or after the effective date of such amendment.

XIV. Entire Agreement:

This Agreement, the Member Enrollment Application of each member, and the Subscriber Contract constitute the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this Agreement shall be binding unless executed in writing by authorized representatives of the parties.

XV. Applicable Law:

The laws of the State of New York shall govern this agreement.

XVI. Inconsistency:

In the event of any inconsistency between this Group Agreement Form and the Subscriber Contract, the terms of this Group Agreement Form shall govern.

Community Rates:

New York State requires HMOs to charge Groups premium rates that are consistent from one Group of the same type to another. This concept is called Community Rating. Easy Choice does not base the premium your Group is charged on the actual cost of providing services to your Group alone, but an average of all Groups which fit into the same category as yours. Easy Choice may, of course charge different premiums for different benefit packages. Easy Choice may also, if we so choose, develop premiums that vary by certain factors such as group size.

Because all HMOs are required to get approval by the New York State Department of Insurance for each benefit package and rider for a specific time period, the HMO is also required to charge and collect premiums equivalent to that approved rate. There are a number of factors, which could impact whether or not your Group is being charged the approved premium rate:

- Timing of Premium Rate Quote;
- The Period which the Premium Rate Quote is different than the community rating period;
- Rate adjustments required due to an over- or undercharge for a prior period.

Group Information

Authorized Signature: _____

Title: _____

Date: _____

Number of Full-Time Employees _____
Number of Part-Time Employees _____
Number of Employees Eligible for Health Insurance Benefits_____

Easy Choice Health Plan of New York

Authorized Signature: _____

Title: _____

Date: _____

Broker/ Sales Agent Information

1. Full legal name of firm/Agent: _____

2. Address of firm/Agent: _____

3. Contact: _____

4. Telephone No. _____

5. SS # or Fed. Tax ID# _____

6. Broker/Agent ID Codes: _____

General Agent Information

1. Full legal name of firm: _____

2. Address of firm: _____

3. Contact: _____

4. Telephone No. _____

5. SS # or Fed. Tax ID# _____

6. GA ID Codes: _____

I acknowledge that my Easy Choice Health Plan of New York identification cards may not be received by the 1st day of my effective month. However, I understand that my benefits will be covered the 1st day of my effective month.

_____
Applicant Signature

_____
Date

EMPLOYEE ENROLLMENT FORM

(Please print & complete in full to avoid any delays)

Easy Choice HEALTH PLAN OF NEW YORK

45 Broadway, Suite 300
New York, NY 10006
Tel: (212) 747-0877
www.atlantishp.com

PLAN OPTION:	☐ HMO ☐ POS ☐ HNY	TYPE OF COVERAGE:	☐ SINGLE ☐ COUPLE ☐ PARENT/CHILD ☐ FAMILY

EMPLOYEE INFORMATION

Last Name	First Name	MI	Date Of Birth	Sex ☐ M ☐ F

Social Security Number	Email Address

Home Address	Apt. No.	City	State	Zip Code

Primary Phone Number	Alternate Phone	Primary Care Physician Name & ID	If married, date of marriage:

Name of Employer	Business Phone

TYPE OF ACTIVITY

☐ New Subscriber ☐ Change of Plan or Primary Care Physician ☐ Termination

☐ Add / Remove Spouse, Dependent Child Reason: _____ Date: _____

DEPENDENT INFORMATION (Please use another enrollment form if you have more dependents)

	Add / Remove	Last Name, First Name, MI	Sex	Date of Birth	Social Security	Primary Care Physician Name & ID
SUBSCRIBER	☐ / ☐			/ /		
SPOUSE	☐ / ☐			/ /		
CHILD 1.	☐ / ☐			/ /		
CHILD 2.	☐ / ☐			/ /		
CHILD 3.	☐ / ☐			/ /		
CHILD 4.	☐ / ☐			/ /		

STUDENT INFORMATION

If dependent children listed are age 19 or older, do they attend school on a full-time basis? ☐ Yes ☐ No	If yes, list first name of child and school	Is any dependent disabled? ☐ Yes ☐ No	If yes, list first name of child

OTHER INSURANCE INFORMATION

Do you, your spouse or dependent children have other Health Insurance? ☐ Yes ☐ No	Name of Insured	Name of Insurance carrier & Policy No.

Give Name of Prior Insurer and Date of Termination	Proof of Prior Coverage

EMPLOYER INFORMATION

Name of Group	Group Number	Contract Plan

Employment Hire Date	Enrollment Effective Date	Date Submitted to AHP	Approved by (employer representative signature):

Is employee active at work? ☐ Yes ☐ No Hours worked per week _____	Move coverage to COBRA: ☐ Yes ☐ No	Qualifying event: _____ Qualifying date: _____

I authorize deductions from my earnings for any required contributions. I authorize all health professionals to provide Easy Choice Health Plan of New York and its contracted professionals, information about health (including mental illness) care advice, treatment or supplies provided to me or my dependents relating to coverage for the purpose of coordinating patient care, evaluating and administering claims for benefits, and for fulfilling Easy Choice Health Plan of New York's obligations under state and federal law. I will discuss any questions concerning the plan with Easy Choice Health Plan of New York 's member services. My signature below affirms eligibility for coverage, and all that information provided is full, complete and true to the best of my knowledge.

I understand that any person who knowingly with intent to defraud any insurance or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and that stated value of the claim for each such violation.

In the absence of creditable coverage Pre-existing Medical Conditions may not be covered for 11 months from the initial enrollment date.

EMPLOYEE/APPLICANT SIGNATURE: X _____ DATE: _____

PREVIOUS INSURANCE COVERAGE FORM

Subscriber: To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following.

Within the last 12 months I have had: *(check one)*

☐ No Prior Coverage ☐ One Insurance Carrier ☐ Multiple Insurance Carriers

Subscriber Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Spouse Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual
Dependent Insurance Carrier Name:	Policy/Subscriber Number :	
Date Coverage Began:	Date Coverage Ended:	
Type Of Policy:	☐ Group	☐ Direct Payment
Coverage Type:	☐ Family	☐ Individual

If additional space is needed for dependents, please complete a separate sheet of paper.

To the best of my knowledge, the information provided above is true and complete. I understand that failure to complete this form may result in denied claim payment for services.

Print Name of Subscriber Signature of Subscriber Date

Easy Choice
HEALTH PLAN OF NEW YORK

DECLARATION OF DOMESTIC PARTNERSHIP

I. DECLARATION:

We, _____and, _____each certify and declare that we are domestic
(employee-print name) (domestic partner-print name)

partners in accordance with the following criteria:

II. STATUS

1. We affirm that this domestic partnership began on or about __/__/__.
2. We are each other's sole domestic partner, and we intend to remain so indefinitely.
3. Neither of us is married to or legally separated from anyone else nor had another domestic partner within the prior six months.
4. We are both at least eighteen (18) years of age and mentally competent to consent to contract.
5. We are not related by blood.
6. We cohabit and reside together in the same residence and intend to do so indefinitely. We have resided in the same household for at least six months.
7. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by at least three of the following (please check appropriate items):
   - ___Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
   - ___Common ownership of a motor vehicle
   - ___Driver's license listing a common address
   - ___Proof of joint bank accounts or credit accounts
   - ___Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will
   - ___Assignment of a durable property power of attorney or health care power of attorney
8. We are not in this relationship solely for the purpose of obtaining benefits coverage.

III. DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of _____(domestic partner-print name) are eligible for coverage when they are:

-unmarried

-primarily dependent on the employee for support, and
-meet the age/school and all eligibility requirements of the plan of benefits.

IV. CHANGE IN DOMESTIC PARTNERSHIP:

1. We have an obligation to notify _____(employer-print name) by filing a Declaration of Termination of Domestic Partnership if there is any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration

(e.g., due to death of a partner, a change in residence of one partner, termination of the relationship, etc.). We will notify _____(employer-print name) within thirty-one (31) days of such change.

2. We understand that termination of this coverage (obtained as a result of completion of this Declaration) will be effective on the date the relationship ends as indicated on the Declaration of Termination of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

V. ACKNOWLEDGMENTS:

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify _____(employer-print name) of changed circumstances as required in Section IV above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify _____(employer-print name), of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.
2. We have provided the information in this Declaration for use by _____(employer-print name) for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that_____(employer-print name) is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential by _____(employer-print name) but will be subject to disclosure; a) upon the express written authorization of the undersigned employee, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.
3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____	__/__/__	__/__/__
Employee Signature	DOB	Date
_____	__/__/__	__/__/__
Domestic Partner Signature	DOB	Date

_____

Employee & Domestic Partner Address

Easy Choice
HEALTH PLAN OF NEW YORK

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____(employee-print name), certify and declare that:_____(former domestic partner-print name) and I are no longer domestic partners as of __/__/__. I understand that coverage for this individual will terminate on this date.

1. I make and file this Declaration of Termination in order to cancel the Declaration of Domestic Partnership filed by me with (employer-print name) on __/__/__.
2. Termination of the Declaration of Domestic Partnership is due to:

___Termination of domestic partnership
___Change of residence
___Marriage to another person
___No longer jointly responsible for each other's common welfare and living expenses
___Death of domestic partner

I understand that another Declaration of Domestic Partnership cannot be filed until six (6) months from the date the relationship ends (as indicated above).

In the event that termination of this relationship is **not** due to the death of my domestic partner, I will mail my former domestic partner a copy of this notice at:

_____

_____
Former domestic partner new address

I affirm, under penalty of perjury, that the above statements are true and correct.

_____ __/__/__
Signature of employee Date

CREDIT CARD/DEBIT CARD PAYMENT AUTHORIZATION

I AUTHORIZE EASY CHOICE HEALTH PLAN OF NEW YORK TO BILL MY CREDIT/DEBIT CARD ACCOUNT INDICATED BELOW FOR PAYMENT OF PREMIUM CHARGES. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS EXCEPT AS NOTED.
I UNDERSTAND THAT AS A CONDITION OF REINSTATEMENT I AM REQUIRED TO PRE-PAY MY MONTHLY PREMIUMS BY AUTOMATIC RECURRING CREDIT CARD OR ACH DEBIT. I ALSO UNDERSTAND THAT SHOULD MY PAYMENT NOT BE AUTHORIZED BY THE ISSUING CREDIT CARD COMPANY, MY POLICY MAY BE TERMINATED FOR NON-COMPLIANCE OF THIS CONDITION OF REINSTATEMENT.

PRINT NAME AS IT APPEARS ON CREDIT/DEBIT CARD_____

BILLING ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ PHONE NUMBER_____

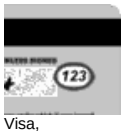
SELECT ONE: ( ) VISA ( ) MASTERCARD ( ) AMERICAN EXPRESS

_____ ___ ___/___ ___ ___ ___
CREDIT/DEBIT CARD NUMBER CARD EXPIRATION DATE

ONE TIME ONLY $_____ ___ ___ ___ ___
Security code

MONTHLY AUTOMATIC RECURRING PAYMENT $_____

How to Locate Your Security Code



Visa, MasterCard

American Express

EASY CHOICE HEALTH PLAN OF NEW YORK ACCOUNT # (GROUP ID/MEMBER ID) : _____

AUTHORIZED SIGNATURE: _____ DATE: _____

BANK DRAFT (ACH) PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE EASY CHOICE HEALTH PLAN OF NEW YORK TO INITIATE MONTHLY DEBIT ENTRIES TO MY CHECKING/SAVINGS ACCOUNT. I UNDERSTAND THAT MY PREMIUM MAY CHANGE UPON ANNUAL RENEWAL AND GIVE PERMISSION TO ADJUST PAYMENT ACCORDINGLY. I UNDERSTAND AND AGREE THAT BY EXECUTING THIS AUTHORIZATION, THIS ACTION DOESN'T AFFECT, WAIVE, OR CHANGE ANY OF THE POLICY'S TERMS, CONDITIONS, AND PROVISIONS, INCLUDING THE POLICY'S PREMIUM PAYMENT AND GRACE PERIOD PROVISIONS EXCEPT AS NOTED. I UNDERSTAND THAT AS A CONDITION OF REINSTATEMENT I AM REQUIRED TO PRE-PAY MY MONTHLY PREMIUMS BY AUTOMATIC RECURRING CREDIT CARD OR ACH DEBIT. I ALSO UNDERSTAND THAT SHOULD MY PAYMENT NOT BE AUTHORIZED BY THE ISSUING CREDIT CARD COMPANY, MY POLICY MAY BE TERMINATED FOR NON-COMPLIANCE OF THIS CONDITION OF REINSTATEMENT.

ACCOUNT HOLDER INFORMATION

LAST NAME:_____ FIRST NAME:_____
(AS IT APPEARS ON YOUR ACCOUNT)

MAILING ADDRESS_____
(AS IT APPEARS ON YOUR ACCOUNT)

CITY_____ STATE_____ ZIP CODE_____--_____

MUST CHOOSE ONE: ONE TIME ONLY $_____

MONTHLY AUTOMATIC (RECURRING) PAYMENT $_____

EASY CHOICE HEALTH PLAN OF NEW YORK ACCOUNT # (GROUP ID/MEMBER ID): _____

AUTHORIZED SIGNATURE: _____ DATE: _____

FINANCIAL INSTITUTION INFORMATION

INSTITUTION NAME_____ BRANCH LOCATION_____

ROUTING NUMBER_____ ACCOUNT NUMBER_____

PLEASE MAKE A NOTE ITEMS RETURNED FOR INSUFFICIENT FUNDS WILL BE ASSESSED A $30 PENALTY FEE. AUTHORIZATION WILL REMAIN IN FULL FORCE AND EFFECT UNTIL EASY CHOICE HEALTH PLAN OF NEW YORK HAS RECEIVED WRITTEN NOTIFICATION FROM THE ACCOUNT HOLDER TO TERMINATE, IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD EASY CHOICE HEALTH PLAN OF NEW YORK A REASONABLE OPPORTUNITY TO ACT ON IT.

YOU CAN FAX YOUR AUTHORIZATION TO 646-929-9222, ATTN: BILLING & ENROLLMENT OR
MAIL TO: EASY CHOICE HEALTH PLAN OF NEW YORK, 45 BROADWAY, SUITE 300, NEW YORK NY 10006

FOR NEW YORK STATE EMPLOYERS

Section 217 of the New York State Labor Law requires that you inform your employees of any plan to terminate their health care coverage. The law requires that a notice from you explaining the reason for the termination be either (1) hand delivered at the place of employment (e.g., by including the notice in the employees' pay envelopes); or (2) mailed to the employees' last known residential address. You must also post a copy of the notice of intent to terminate and the required covering letter in a conspicuous location. These actions must be taken at least nine days prior to the intended termination date.

The law does not apply if, at least 10 days prior to the date of the intended termination, you have (1) taken necessary steps to render an Easy Choice Health Plan of New York notice of termination null and void, such as mailing the required premium; or (2) contracted with another insurer for similar coverage for the same certificate holders, and filed an affidavit with the Commissioner of Labor and Superintendent of Insurance to that effect.

Prescription Rider Rx C – 20/30/40

The following rider is an addendum to the "Subscriber Contract" which provides for the provision of all basic health services.

Benefits

The "Benefits" section of the Subscriber Contract is amended as follows:

Outpatient Prescription Drugs or Medicines

- Outpatient Food and Drug Administration (FDA) approved prescription drugs or medicines are covered when medically necessary and prescribed by a licensed Provider. Each prescription is limited to a maximum 34-day supply, with up to four refills when authorized by a licensed Provider.
- If you purchase a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and then submit a claim for reimbursement from the Plan. Reimbursement for drugs purchased at non-participating pharmacies will be limited to the Reasonable Charge for the drug minus the co-payment.

Prescription drug coverage also includes:

- Medically necessary enteral formulas for home use when prescribed by a licensed provider. The formula must have been proven effective as a disease-specific treatment regime for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death.
- Modified solid food products that are low protein, when medically necessary for certain inherited diseases of amino acids and organic metabolism. The maximum coverage for any authorized modified solid food products for any calendar year or for any continuous period of 12 months shall not exceed $2,500
- Hypodermic needles and syringes used to administer medications that are covered by Easy Choice Health Plan of New York, when prescribed by a licensed practitioner and purchased through a Plan Pharmacy.
- Certain non-FDA approved prescribed drugs recognized for the treatment of specific types of cancer by one of the following:
    A. The American Hospital Formulary Service-Drug Information
    B. National Comprehensive Cancer Networks Drugs and Biologics Compendium
    C. Thompson Micromedex DrugDex
    D. Elsevier Gold Standard's Clinical Pharmacology
    E. Authoritative compendia identified by the Federal Secretary of Health and Human Services or by the Centers for Medicare and Medicaid Services (CMS) or recommended by a review article or editorial comment in a major peer reviewed professional journal.
- Pre-natal Vitamins for pregnant women ONLY, when prescribed by a licensed provider.
- Allergy Serums.

Generic Mail Order / Brand Maintenance Mail Order Drug Programs

You are encouraged to utilize our Generic Mail Order / Brand Maintenance Mail Order drug programs if you are required to use a maintenance drug on the Plan's approved list.

a) **Brand Maintenance Mail Order Program:** Brand Maintenance drugs on the Plan's approved list are covered for a 90-day supply with a written prescription by a Provider. This mail order option allows you to obtain a 90-day supply of brand maintenance drugs in the following categories: anti-diabetics,

anti-hypertensives, anti-hyperlipidemics, beta-blockers, calcium blockers, diuretics, anti-seizure, contraceptives and thyroid medications. Prescriptions must filled at the Easy Choice Health Plan of New York approved Brand Maintenance Mail Order Pharmacy.

b) **Generic Drug Mail Order Program:** Generic drugs are covered with a written prescription by a Provider. Prescriptions must be filled at the Easy Choice Health Plan of New York approved Generic Drug Mail Order Pharmacy.

Co-payments

- You are responsible for a $20 co-payment for each generic prescription filled at a Pharmacy.
- You are responsible for a $30 co-payment for each brand formulary prescription filled at a Pharmacy.
- You are responsible for a $40 co-payment for each brand non-formulary prescription filled at a Pharmacy.
- You are responsible for a $0 co-payment for each mail order generic prescription.
- You are responsible for a copayment of one and half times (1.5x) the regular copay for 90 day brand maintenance mail order drugs.

Limitations and Exclusions

Except to the extent that such benefits are either medically necessary or are required to be provided by applicable Law, prescription drug benefits do *not* include:

1. Any drug which does not require a prescription, such as over-the-counter or non-legend drugs, even if a prescription is written.
2. Any durable medical equipment appliance or device.
3. Some drugs and medications used to treat infertility may be covered, based upon the requirements of New York State Law.
4. Antibacterial soaps/detergents, shampoos, toothpaste/gels and mouthwashes/rinses.
5. Prescription drugs dispensed to a Member while he is a patient in a hospital, nursing home, or other institution.
6. Prescription drugs used in connection with drug addiction, unless medically necessary and pre-authorized by Easy Choice Health Plan of New York.
7. Amphetamines, appetite suppressants, and hair growth stimulants unless medically necessary and pre-authorized by Easy Choice Health Plan of New York.
8. Medications for cosmetic purposes only.
9. Prescription drugs dispensed by a physician/provider office.
10. Experimental and Investigational Drugs which are defined as drugs which have not been approved by the FDA and or NIH or have not been shown to be safe and effective through clinical trials or are not generally accepted as safe and effective by a majority of clinical providers with significant experience in the usage of the drugs.
11. Replacements of drugs resulting from loss, theft or breakage.
12. Some drugs require Pre-authorization. Provider/Member is responsible for obtaining the necessary authorization prior to prescribing the drug.

All of the terms, conditions and limitations of your Easy Choice Health Plan of New York HMO Subscriber Contract to which this rider is attached also apply to this Rider, except where specifically changed by this Rider.

EASY CHOICE HEALTH PLAN OF NEW YORK

Summary of Benefits

HMO: Low Option Plan 20

DOCTOR'S SERVICES	**What You Pay**
Office Visits (PCP or Specialist)	$20 co-payment
Ambulatory Service visits (Hemodialysis, Chemotherapy, Radiotherapy)	$20 co-payment
Inpatient Hospital Visits	No co-payment
Allergy Testing and Treatment	$20 co-payment
Anesthesia	No co-payment
Diagnostic Services and Treatments	$20 co-payment
Mammography Screening and Prostate Cancer Screening	$20 co-payment
Mastectomy Care	$20 co-payment
Obstetrical/Gynecological Services and Pap Smears	$20 co-payment
Radiology Services	$20 co-payment
Infertility Services	$20 co-payment
Bone Mineral Density Measurements, Testing and Devices	$20 co-payment
Enteral Formulas	$20 co-payment
Contraceptive drugs and devices	$20 co-payment
All second surgical/medical opinions	$20 co-payment
Periodic routine physicals	$20 co-payment
Well-Child Visits	No co-payment
Experimental or investigational services recommended by external appeal agent	$20 co-payment
Pre- & Post-Natal Care	$20 co-payment
Chiropractic Care	$20 co-payment
Delivery Of Child/ Ambulatory and Outpatient Surgery	Lesser of: 20% or $200
AMBULATORY SERVICES	
Ambulatory/Out patient Facility Services	$75 co-payment
Pre-admission Testing	$20 co-payment
X-ray and Laboratory Services	$20 co-payment
HOSPITAL SERVICES	
Inpatient Services	$500 co-payment
Inpatient Cardiac Rehabilitation (per continuous confinement)	$500 co-payment
Ambulatory Surgery Facility	$75 co-payment
Blood and Blood Products	No co-payment
Ambulance Services	$50 co-payment
Emergency Room Care (no admission to hospital)	$50 co-payment
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility: 30 days per calendar year* (per continuous confinement)	$500 co-payment
Home Health Care: 40 visits per calendar year	$20 co-payment
End of Life Care Program	No co-payment
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment
Hospice Care- Outpatient bereavement counseling-5 visits	No co-payment
Hospice Care: Outpatient	No co-payment
REHABILITATIVE SERVICES	
Physical/Speech/Occupational	
Inpatient: per continuous confinement (Limited to 30 days per diagnosis per calendar year)	$500 co-payment
Outpatient: limited to 20 visits per diagnosis per calendar year (only following inpatient stay)	$20 co-payment
MENTAL HEALTH	
Inpatient Admission: per continuous confinement (30 days per calendar year)	$500 co-payment
Outpatient: 20 visits per calendar year	$20 co-payment
SUBSTANCE ABUSE	
Inpatient Detoxification: per continuous confinement (Limited to 7 days per calendar year)	$500 co-payment
Outpatient Rehabilitation: 60 visits per calendar year (20 of the visits may be used for Family Therapy)	$20 co-payment
MEDICAL EQUIPMENT & SUPPLIES	
Durable Medical Equipment & Supplies	20% co-insurance
Diabetic Equipment and Supplies	$20 co-payment

* Benefit riders available to satisfy the "make available" provisions of Section 4303(e) of the New York State Insurance Laws

Note 1: Benefit limitations and maximums are per Member per calendar year.

Note 2: The benefits outlined in this summary may have been modified as a result of healthcare reform. If applicable, please see PPACA Rider under separate cover.

EXCLUSIONS: This SUMMARY OF BENEFITS highlights the standard benefits of the HMO contract.

Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Group Subscriber Contract.

Prescription Rider Rx M "Mandatory Generic"
PPACA

The following rider is an addendum to the "Group Subscriber Certificate of Coverage" which provides for the provision of all basic health services.

Benefits

The "Benefits" section of the Group Subscriber Certificate of Coverage is amended as follows:

Outpatient Prescription Drugs or Medicines:

- This rider covers only generic prescription drugs. Brand name prescription drugs are not covered.
- Outpatient Food and Drug Administration (FDA) approved prescription drugs or medicines are covered when medically necessary and prescribed by a licensed Provider. Each prescription is limited to a maximum 30-day supply, with up to four refills when authorized by a licensed Provider.
- If you purchase a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and then submit a claim for reimbursement from the Plan. Reimbursement for drugs purchased at non-participating pharmacies will be limited to the Reasonable Charge for the drug minus the co-payment.

Prescription drug coverage also includes:

- Medically necessary enteral formulas for home use when prescribed by a licensed provider. The formula must have been proven effective as a disease-specific treatment regime for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. This rider covers brand name and generic enteral formulas.
- Modified solid food products that are low protein, when medically necessary for certain inherited diseases of amino acids and organic metabolism.
- Hypodermic needles and syringes used to administer medications that are covered by Easy Choice Health Plan of New York, when prescribed by a licensed practitioner and purchased through a Plan Pharmacy.
- Certain non-FDA approved prescribed drugs, whether brand name or generic, recognized for the treatment of specific types of cancer by one of the following:
    A. The American Hospital Formulary Service-Drug Information
    B. National Comprehensive Cancer Networks Drugs and Biologics Compendium
    C. Thompson Micromedex DrugDex
    D. Elsevier Gold Standard's Clinical Pharmacology
    E. Authoritative compendia identified by the Federal Secretary of Health and Human Services or by the Centers for Medicare and Medicaid Services (CMS) or recommended by a review article or editorial comment in a major peer reviewed professional journal.
- Allergy Serums, whether brand name or generic.

AHP-RIDER-RXM-P
DOI Approved 11232010

- Bone mineral density brand name and generic prescription drugs and devices including those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health and if consistent with such criteria, dual-energy x-ray absorptiometry. Covered Services shall be provided to a Member who qualifies under the criteria of the federal Medicare program and the criteria of the National Institutes of Health. This includes a Member who meets the following criteria:
    i. The Member has previously been diagnosed with osteoporosis or has a family history of osteoporosis; or
    ii. The Member has symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
    iii. Member is on a prescribed drug regimen posing a significant risk of osteoporosis, or
    iv. The Member's age, gender, other physiological characteristics and/or lifestyle factors pose a significant risk of osteoporosis.
- For Members between the ages of twenty-one (21) and forty-four (44), brand name and generic prescription drugs approved by the federal FDA for use in the diagnosis and treatment of infertility. There is no coverage for Prescription drugs used in connection with any infertility service which is specifically excluded from coverage.
- You have the right to file an appeal with an independent, outside review panel whenever the Plan denies coverage for prescription drugs because the drug is not considered medically necessary or is considered an experimental or investigational treatment. Further details as to how you may request an appeal are provided in the Certificate of Coverage.

Generic Mail Order Drug Program

You are encouraged to utilize our Generic Mail Order drug program. Generic drugs are covered with a written prescription by a Provider. Prescriptions must be filled at the Easy Choice Health Plan of New York approved Generic Drug Mail Order Pharmacy.

Co-payments

- You are responsible for an annual deductible of $0 per covered member for a generic drug.
- You are responsible for a $10 co-payment for each generic prescription filled at a Pharmacy.
- You are responsible for a $0 co-payment for each mail order generic prescription.

Limitations and Exclusions

Except to the extent that such benefits are either medically necessary or are required to be provided by applicable Law, prescription drug benefits *do not* include:

1. All non-generic classified prescription drugs.
2. Any drug which does not require a prescription, such as over-the-counter or non-legend drugs, even if a prescription is written.
3. Antibacterial soaps/detergents, shampoos, toothpaste/gels and mouthwashes/rinses.
4. Prescription drugs dispensed to a Member while he is a patient in a hospital, nursing home, or other institution.
5. Prescription drugs used in connection with drug addiction, unless medically necessary and pre-authorized by Easy Choice Health Plan of New York.
6. Amphetamines, appetite suppressants, and hair growth stimulants unless medically necessary and pre-authorized by Easy Choice Health Plan of New York.
7. Medications for cosmetic purposes only.
8. Prescription drugs dispensed by a provider office.
9. Experimental and Investigational Drugs which are defined as drugs which have not been approved by the FDA and or NIH or have not been shown to be safe and effective through clinical

trials or are not generally accepted as safe and effective by a majority of clinical providers with significant experience in the usage of the drugs, unless recommended by an external appeal agent.

10. Replacements of drugs resulting from loss, theft or breakage.

Other limitations on coverage are as follows:

1. The maximum coverage for any authorized modified solid food products for any continuous period of 12 months shall not exceed $2,500.
2. Some drugs require Pre-authorization. Provider/Member is responsible for obtaining the necessary authorization prior to prescribing the drug.
3. Prescription drug coverage does not include prescription contraceptive drugs or devices unless covered by a separate Contraceptive Coverage Rider.

All of the terms, conditions and limitations of your Easy Choice Health Plan of New York HMO Subscriber Contract to which this rider is attached also apply to this Rider, except where specifically changed by this Rider.