Empire's Alternate PPO for the Dutchess Educational Health Insurance Consortium

PPO

6/2011

Welcome!

Welcome to Empire's PPO. With Empire BlueCross BlueShield, you have access to great coverage, flexibility and all the advantages of quality care. This benefits book explains exactly how you access healthcare services, what your health plan covers and how we can help you make the most of your plan.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

YOUR PPO – A SMART WAY TO GET HEALTHCARE

Your PPO, or Preferred Provider Organization, is a group healthcare plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield. The PPO offers a network of healthcare providers available to you through Empire. If you think about your town, it includes doctors, hospitals, laboratories and other medical facilities that provide healthcare services – that's what we mean by healthcare "providers." Some healthcare providers contract with health plans like Empire BlueCross BlueShield to provide services to members as part of the plan's "network."

With Empire's PPO, when you need healthcare services, you have a choice. Depending on the healthcare service you need, you are free to get care from providers participating in your PPO network or you can choose to use outside providers. You are covered for medically necessary services no matter which you choose.

WHAT'S THE EMPIRE PPO ADVANTAGE?

When you use Empire's PPO network to access healthcare, you get:

- **A comprehensive Web site, *www.empireblue.com*, for fast, personalized, secure information**
- Among the largest network of doctors and hospitals in New York State
- Providers that are continuously reviewed for Empire's high standards of quality
- The ability to choose in-network or out-of-network care for most covered services
- Minimal out-of-pocket costs for preventive care, behavioral healthcare and a wide variety of hospital and medical services when you stay in-network
- Easy to use – no claim forms to file when you stay in-network
- Coverage for you and your family when traveling or living outside of Empire's service area

HOW TO USE THIS GUIDE

This Guide gives you an overview of the features and benefits of your plan. Use it as a reference to find out what's covered, what your costs are, and how to get healthcare services any time you or a covered family member need them.*

You'll find the information you need divided into sections. Here's a quick reference:

	IF YOU ARE LOOKING FOR …	YOU'LL FIND IT IN	ON PAGE
•	HOW THE PLAN WORKS	USING YOUR PPO	6
•	WHAT'S COVERED	COVERAGE	18
•	PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	38
•	HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	44

OUR ROLE IN NOTIFYING YOU

There may be times when benefits and/or procedures may change. We or your employer will notify you of any change in writing. Announcements will go directly to you at the address that appears on our records or to your group benefits office.

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* *This Guide describes only the highlights of your medical coverage. It does not attempt to cover all the details. Additional details are provided in the plan documents and insurance and/or service contracts, which legally govern the plan. In the event of any discrepancy between this Guide and the plan documents, the plan documents will govern.*

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

Go to ***www.empireblue.com*** where you can securely manage your health plan 24 hours a day, 7 days a week. Here's what you can do:

- Check status of claims
- Search for doctors and specialists
- Update your member profile
- Get health information and tools with My Health powered by WebMD
- Print plan documents
- Receive information through your personal "Message Center"
- Visit the Pharmacy

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

All members of your family 18 or older must register separately:

- **Go to *www.empireblue.com***
- Click on the Member tab and choose "Register"
- Follow the simple registration instructions

ASSISTANCE IS A CLICK AWAY

Use the Click-to-Talk feature to contact us three different ways:

- **E-mail**: You can e-mail us with a question 24 hours a day, 7 days a week, and a customer service representative will e-mail an answer back to you through your Message Center.
- **Collaboration**: Our representative will call you while you are online and navigate the site along with you. We can even take control of your mouse, making it easier to answer your questions.
- **Call Back**: You can request that a representative contact you with assistance.

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

Click on MY HEALTH from your secure homepage after you register to receive the following features:

- Take the *Health IQ* test and compare your score to others in your age group
- Find out how to improve your score – *and your health* – online
- Find out how to take action against chronic and serious illnesses

Get health information for you and your family.

YOUR PRIVACY IS PROTECTED

Your information is protected by one of the most advanced security methods available.

Register today to experience hassle-free service!
www.empireblue.com

Your PPO Guide

Introduction

Getting Answers Your Way

Empire gives you more choices for contacting us with your customer service questions. Use the Internet, phone or mail to get the information you need, when you need it.

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit *www.empireblue.com*. At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially. Nervous about using your PC for important healthcare questions or transactions? We've addressed that too! Just "click to talk" to a representative or send us an e-mail.

BY TELEPHONE

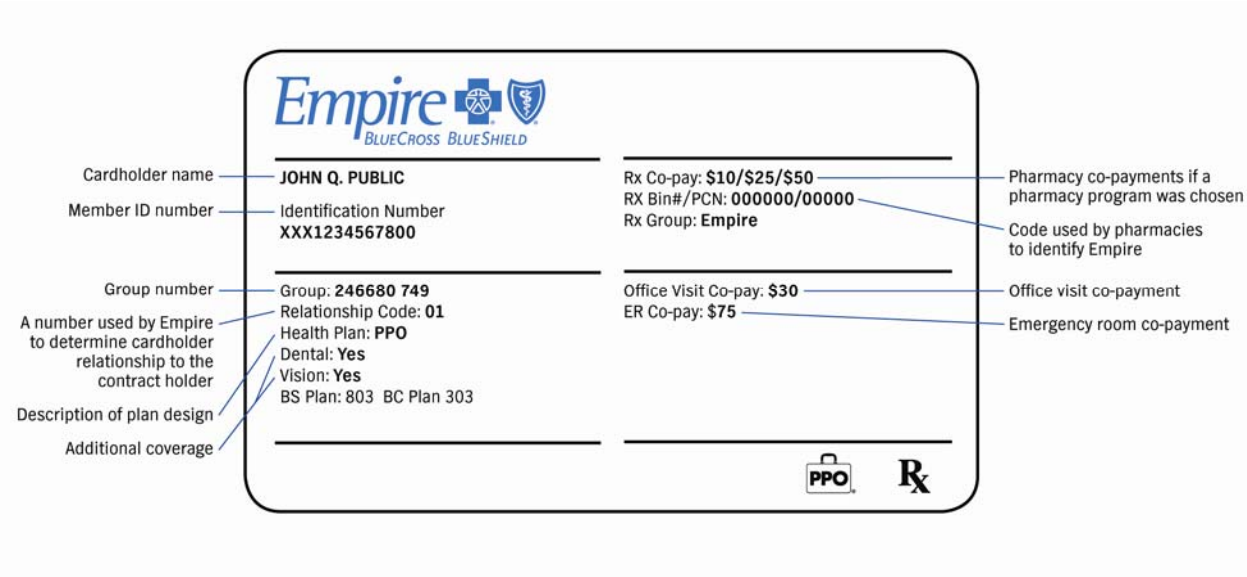
WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** *www.bcbs.com* 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures.	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
EMPIRE PHARMACY MANAGEMENT PROGRAM	Information about the program Locate a participating retail pharmacy Obtain a complete drug formulary list	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 7:00 a.m. to 10:00 p.m. Monday –- Friday 9:00 a.m. to 9:00 p.m. Saturday 9:00 a.m. to 5:30 p.m. Sunday
VISION CARE	To find a participating Davis vision network provider in your area	**1-877-923-2847** 8:00 a.m. to 8:00 p.m. Monday –- Friday 9:00 a.m. to 4:00 p.m. Saturday
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

IN WRITING

Empire BlueCross BlueShield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Your Identification Card

Empire has created an identification card to make accessing your healthcare as easy as possible. The Empire BlueCross BlueShield I.D. card is a single card that you can use for all your Empire health insurance services, as it shows each of the plans or programs you're enrolled in. Always carry it and show it each time you receive healthcare services. Every covered member of your family will get their own card. The information on your card includes your name, identification number, and various co-payment amounts. Below is an example of an Empire ID card.



To make it easier for you to use your new card, following are answers to some frequently asked questions:

Q: *Why is Empire issuing this kind of I.D. card?*

A: Empire's card has all the information providers need to know to serve our members' healthcare needs. Our design eliminates the need for you to carry multiple cards.

Q: *Why does each family member get a separate I.D. card?*

A: By giving your family members their own card with their own name on it, providers know right away that each family member is covered by the plan – even dependents. If someone in your family happens to forget the card, he or she can still use another family member's card. (In a few instances, family members in some groups will receive two I.D. cards in the member's name only. These cards will be used for all family members.)

Q: *How can I replace a lost I.D. card?*

A: Visit *www.empireblue.com* or call Member Services. By visiting us on-line, you can also print a temporary identification card for your immediate use.

Using Your PPO

Know the Basics

The key to using your PPO plan is understanding how benefits are paid. Start by choosing in-network or out-of-network services any time you need healthcare. Your choice determines the level of benefits you will receive.

You can view and print up-to-date information about your plan or request that information be mailed to you by visiting ***www.empireblue.com.***

USE YOUR PPO TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your PPO to your best advantage will help ensure that you receive high quality healthcare – with maximum benefits. Here are three ways to get the most from your coverage.

- BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.
- PLEASE REMEMBER TO PRECERTIFY hospital, ambulatory surgery (for medically necessary cosmetic/ reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. You'll recognize these services when you see this sign. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.
- ASK QUESTIONS about your healthcare options and coverage. To find answers, you can:
  - Read this Guide.
  - Call Member Services when you have questions about your benefits in general or your benefits for a specific medical service or supply.

Call *24/7 NurseLine and AudioHealth Library* -- available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.

Talk to your provider about your care, learn about your benefits and your options, and ask questions. Empire is here to work with you and your provider to see that you get the best benefits while receiving the quality healthcare you need.

CHOOSING IN-NETWORK OR OUT-OF-NETWORK SERVICES

In-network services are health care services provided to a member by a doctor, hospital or healthcare facility in Empire's provider network or in the network of another BlueCross and/or BlueShield plan that participates in the BlueCard PPO Program. When you choose in-network care, you get these advantages:

- CHOICE – You can choose any participating provider from the largest network of doctors and hospitals in New York State or the network of Blue Cross and Blue Shield plans through the BlueCard® PPO Program.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a small co-payment for office visits and many other services.
- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- CONVENIENCE – Usually, there are no claim forms to file.
- Out-of-network services are healthcare services provided by a licensed provider outside Empire's PPO network or the BlueCard PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:
  - You pay an annual deductible and coinsurance, plus any amount above the allowed amount (the maximum Empire will pay for a covered service) ; if you use a BlueCard provider, you will pay only the lower of billed charges or a negotiated rate and your member liability
  - You will usually have to pay the provider when you receive care
  - You will need to file a claim to be reimbursed by Empire

Here's an example of how costs compare for in-network and out-of-network care.

	IN-NETWORK	OUT-Of-NETWORK
PROVIDER'S CHARGE	$500	$500
ALLOWED AMOUNT	$400	$400
PLAN PAYS PROVIDER	$385	$280 (70% of allowed amount)
YOU PAY PROVIDER	$15 co-payment	$220 (30% of allowed amount, plus the $100 above the allowed amount. Assumes you have satisfied your deductible)

The following chart shows your specific plan information.
See the Details and Definitions section for explanations of terms in the chart.

	IN-NETWORK	OUT-Of-NETWORK
ANNUAL DEDUCTIBLE*	$0	$300/Individual $750/Family
CO-PAYMENT (for office visits and certain covered services)	$15 per visit	N/A
CO-PAYMENT (for hospital inpatient admissions)	$0	N/A
CO-PAYMENT (for emergency room)	$35 per visit (waived if admitted to hospital within 24 hours)	$35 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	N/A	You pay 30% of allowed amount. Plan pays 70% of allowed amount
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	N/A	$750/Individual $1,250/Family
LIFETIME MAXIMUM	Unlimited	Unlimited

WHERE TO FIND NETWORK PROVIDERS

Empire's PPO network gives you access to providers within the plan's operating area of 28 eastern New York State counties. See "operating area" in the Details and Definitions section for a listing of counties.

To locate a provider in Empire's operating area, visit ***www.empireblue.com.*** You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Or, ask your Benefits Administrator to see Empire's PPO Directory.

You can also request that a directory be mailed to you free of charge by calling Member Services at 1-800-342-9816.

Call 1-800-810-BLUE (2583) or visit www.bcbs.com to locate participating BlueCard PPO® providers.

* *If you had group coverage under a major medical or extended medical plan with Empire prior to your PPO effective date, we will apply any deductible met under that prior contract in the same calendar year to your PPO deductible. For services rendered in October, November or December, deductible credit will be applied to the following year's deductible.*

YOUR PPO BENEFITS OUT-OF-AREA†

When you live or travel outside of Empire's operating area, Empire's PPO provides benefits through the following BlueCard® programs.

Inside U.S. through the BlueCard® PPO program

BlueCard PPO is a national PPO program that links Blue Cross and/or Blue Shield PPO providers and local Blue Cross and Blue Shield plans across the country.

Inside the U.S., BlueCard PPO network providers are considered in-network providers. When you obtain medically necessary covered healthcare services from providers participating in the BlueCard PPO program, you receive the same benefits and the same in-network coverage across the country. The suitcase logo on your ID card indicates that you are a member of the BlueCard PPO program. BlueCard PPO providers submit the claims, and you are responsible only for your member liability.

Inside U.S. through the BlueCard® Program

Empire participates in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. Inside the U.S. BlueCard network providers are considered out-of-network providers except for emergency services. The BlueCard program gives you access to care when you are outside of Empire's service area on an out-of-network basis anywhere in the United States. By presenting your identification card to any BlueCard participating hospital, physician or other provider outside Empire's service, you will receive the covered services you would be entitled to receive within Empire's service area and you will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield plan subject to certificate limitations that apply to coverage outside Empire's service area.

When you obtain healthcare services through the BlueCard program, the portion of your claim (your member liability) for covered services that you are responsible for will be based on the lower of the provider's billed charges or the negotiated price the local Blue Cross and/or Blue Shield plan has with the provider.

BLUECARD® WORLDWIDE PROGRAM

Outside U.S. (BlueCard® Worldwide Program)

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.

Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the allowed amount.

† *See the Details and Definitions section for more information on the BlueCard and BlueCard Worldwide programs.*

Women's Health and Cancer Rights Act of 1998

This federal law applies to almost all health care plans, except Medicare Supplement and Medicare Risk plans, as of plan years beginning on or after October 21, 1998. The law imposes certain requirements on employee benefit plans and health insurers that provide medical and surgical benefits with respect to a mastectomy. Specifically, in the case of a participant or beneficiary who receives benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the law requires coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

The coverage described above shall be provided in a manner determined in consultation with the attending physician and the patient. This coverage is subject to all coverage terms and limitations (for example, Deductibles and Coinsurance) consistent with those established for other benefits under the plan.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Program or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Your Benefits at a Glance

Empire's plan provides a broad range of benefits to you and your family. Following is a brief overview of your coverage. Some services require precertification with Empire's Medical Management Program. See the Health Management section for details.

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
OFFICE VISITS	$15 co-payment per visit	Deductible and 30% coinsurance
SPECIALIST VISITS	$15 co-payment per visit	Deductible and 30% coinsurance
CHIROPRACTIC VISITS	$15 co-payment per visit	Deductible and 30% coinsurance
SECOND OR THIRD SURGICAL OPINION**	$15 co-payment per visit	Deductible and 30% coinsurance
DIABETES EDUCATION AND MANAGEMENT	$15 co-payment per visit	Deductible and 30% coinsurance
ALLERGY CARE • Office Visit • Testing • Treatment	 $15 co-payment per visit $0 $0	Deductible and 30% coinsurance
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy • MRIs/MRAs • Nuclear cardiology services • PET/CAT scans • Laboratory tests	 $0 $0 $0 $0 $0 $0	Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SURGERY	$0	Deductible and 30% coinsurance
CHEMOTHERAPY	$0	Deductible and 30% coinsurance
X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	Deductible and 30% coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$15 co-payment per visit	Deductible and 30% coinsurance
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL PHYSICAL EXAM • One per calendar year	$0	Not covered
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Over age 50-: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age • Diagnostic PSA: 1 per year	$0 $0 $0 $0 $0	Deductible and 30% coinsurance
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment – Ages 55 through 65 - 1 baseline – Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)* • Mammogram (based on age and medical history) – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year	$0 $0 $0 $0	Deductible and 30% coinsurance
WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits – Newborn: 2 in-hospital exams at birth following vaginal delivery – Newborn: 4 in-hospital exams at birth following c-section delivery • Office visits – From birth up 1st birthday: 7 visits – Ages 1 through 4 years of age: 6 visits – Ages 5 through 11 years of age: 7 visits – Ages 12 up to 17 years of age: 6 visits – Ages 18 to 21st birthday: 2 visits • Lab tests • Immunizations (office visits are not required) **Certain preventive care services are subject to age and frequency limitations.**	$0 $0 $0 $0	Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
EMERGENCY ROOM	$35 per visit co-payment (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	$15 co-payment per visit	Deductible and 30% coinsurance
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	$0	You pay the difference between the allowed amount and the total charge.
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the allowed amount	Subject to in-network benefits
MATERNITY CARE AND REPRODUCTIVE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PRENATAL AND POSTNATAL CARE (In doctor's office)	$0	Deductible and 30% coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	Deductible and 30% coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0	Deductible and 30% coinsurance
OBSTETRICAL CARE (In hospital)	$0	Deductible and 30% coinsurance
ADVANCED REPRODUCTIVE TECHNOLOGIES	$0	Not covered
INFERTILITY TREATMENT	$0	Deductible and 30% coinsurance
OBSTETRICAL CARE (In birthing center)	$0	Not covered

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
HOSPITAL SERVICES[1]	**IN-NETWORK**	**OUT-OF-NETWORK**
ANESTHESIA AND OXYGEN	$0	Deductible and 30% coinsurance
BLOOD WORK	$0	Deductible and 30% coinsurance
CARDIAC REHABILITATION	$15 co-payment per outpatient visit	Deductible and 30% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	$0	Deductible and 30% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	Deductible and 30% coinsurance
DRUGS AND DRESSINGS	$0	Deductible and 30% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	Deductible and 30% coinsurance
INTENSIVE CARE	$0	Deductible and 30% coinsurance
KIDNEY DIALYSIS	$0	Deductible and 30% coinsurance
PRE-SURGICAL TESTING	$0	Deductible and 30% coinsurance
SEMI-PRIVATE ROOM AND BOARD	$0	Deductible and 30% coinsurance
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	Deductible and 30% coinsurance
SURGERY (Inpatient and Outpatient) **	$0	Deductible and 30% coinsurance
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK**
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	$0	Not covered
ORTHOTICS	$0	Not covered
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	$0	Not covered
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	$0	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	$0	Deductible and 30% coinsurance

[1] *Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation. Residential treatment services are not covered.*

** *For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.*

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY Up to 365 days per calendar year	$0	Not covered
HOSPICE Up to 210 days per lifetime	$0	Not covered
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
HOME HEALTH CARE Up to 365 visits per calendar year (a visit equals 4 hours of care) **	$0	30% coinsurance only. No deductible
HOME INFUSION THERAPY	$0	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICAL THERAPY AND REHABILITATION Unlimited days of inpatient service per calendar year • Unlimited home, office or outpatient facility per calendar year	$0 inpatient $0 co-pay outpatient facility $15 co-pay per visit home or office	Deductible and 30% coinsurance Not covered
OCCUPATIONAL, SPEECH, VISION THERAPY ** • Up to 30 visits per person combined home, office or outpatient facility per calendar year	$0 co-pay outpatient facility $15 co-pay per visit home or office	Not covered Not covered

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

** *Treatment maximums are combined for in-network and out-of-network care.*

	YOU PAY	
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits	**Outpatient Facility** $0 **Outpatient Office** $15 co-payment per visit	Deductible and 30% coinsurance Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days • Unlimited number of medically necessary visits from mental healthcare professionals	$0 $0	Deductible and 30% coinsurance Deductible and 30% coinsurance
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-Of-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits, including visits for family counseling	**Outpatient Facility** $0 **Outpatient Office** $15 co-payment per visit	Deductible and 30% coinsurance Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days of detoxification • Unlimited number of medically necessary rehabilitation days	$0 $0	Deductible and 30% coinsurance Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
PHARMACY (RETAIL AND MAIL ORDER) [2]	**IN-NETWORK**	**OUT-Of-NETWORK**
RETAIL • Card Program	$5 co-payment for generic $5 co-payment plus ancillary charge for multi-source brand $20 co-payment for single source brand	Not covered
• Mail Order	$10 co-payment generic for 90 day supply $10 co-payment plus ancillary charge for multi-source brand for 90 day supply $40 co-payment for single source brand for 90 day supply.	Not covered
(All of the prescription drug options listed above meet the Centers for Medicare and Medicaid Services (CMS) standards for Medicare prescription drug coverage and each option is considered Creditable Coverage under the Medicare Modernization Act of 2003.)		

[2]*Refer to managed drug requirements on pages 32 and 33*

VISION[4]	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM (Only available through a Davis Vision network provider) • One eye exam every 24 months **FRAMES** (limited selection)	$5 copay per visit $10 copay per pair $35 allowance for non plan frames	Not covered
LENSES (single vision, bifocal or trifocal)	$0 copay per pair	Not covered
SOFT CONTACT LENSES	$25 copay per pair	Not covered
NON-PLAN SOFT CONTACT LENSES	$75 allowance	Not covered

[4] *See Vision Care section for additional co-payment allowances*

Coverage

Doctor's Services

When you need to visit your doctor or a specialist, Empire makes it easy. In-network, you pay only a co-payment There are no claim forms to fill out for X-rays, blood tests or other diagnostic procedures – as long as they are requested by the doctor and done in the doctor's office or a network facility. For in-network allergy office visits, you pay only a co-payment. In-network allergy testing is covered in full. Ongoing in-network allergy treatments are covered in full.

When you visit an out-of-network physician or use an out-of-network facility for diagnostic procedures, including allergy testing and treatment visits, you pay the deductible and coinsurance, plus any amount above Empire's allowed amount.

Tips For Visiting Your Doctor

- When you make your appointment, confirm that the doctor is an Empire network provider and that he/she is accepting new patients.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to an outside lab or radiologist for tests or X-rays, call Member Services to confirm that the supplier is in Empire's network. This will ensure that you receive maximum benefits.

Ask about a second opinion anytime that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist, as long as your participating doctor provides a written referral to a non-participating specialist. If you visit a non-participating specialist without a written referral, you must pay the out-of-network deductible and coinsurance.

What's Covered

Covered services are listed in *Your Benefits at a Glance* section. Following are additional covered services and limitations:

- Consultation requested by the attending physician for advice on an illness or injury
- Diabetes supplies prescribed by an authorized provider:
  - Blood glucose monitors, including monitors for the legally blind
  - Testing strips
  - Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
  - Oral agents for controlling blood sugar
  - Other equipment and supplies required by the New York State Health Department
  - Data management systems
- Diabetes self-management education and diet information, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis
    - When the patient's condition changes significantly
    - When medically necessary
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  - Home visits for education when medically necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition

- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care (your provider must call Empire's Medical Management Program to determine medical necessity of services after the fifth visit)

What's Not Covered

The following medical services are not covered:

- Routine foot care, including care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain
- Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
- Orthotics for treatment of routine foot care
- Routine hearing exams
- Hearing aids and the examination for their fitting
- Services such as laboratory, X-ray and imaging, and pharmacy services as required by law from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship
- Services given by an unlicensed provider or performed outside the scope of the provider's license

Emergency Care

IF YOU NEED EMERGENCY CARE

Should you need emergency care, your plan is there to cover you. Emergency care is covered in the hospital emergency room.

To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

2. Serious impairment to such person's bodily functions;

3. Serious dysfunction of any bodily organ or part of such person; or

4. Serious disfigurement of such person.

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an 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.

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 NurseLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same co-payment as for an office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

Remember: You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

If you are admitted to the hospital, you or someone on your behalf must call Empire's Medical Management Program before services are rendered or within 48 hours after you are admitted to or treated at the hospital, or as soon as reasonably possible. If you do not obtain authorization from Empire within the required time, a penalty of 50% of benefits will apply.

Tips For Getting Emergency Care

- If time permits, speak to your physician to direct you to the best place for treatment
- If you have an emergency while outside Empire's service area anywhere in the United States, follow the same steps described on the previous page. If the hospital participates with another Blue Cross and/or Blue Shield plan in the BlueCard® PPO program, your claim will be processed by the local plan. Be sure to show your Empire I.D. card at the emergency room, and if you are admitted, notify Empire's Medical Management Program within 48 hours of admission. If the hospital does not participate in the BlueCard PPO program, you will need to file a claim.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard® Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

What's Not Covered

These emergency services are not covered:

- Use of the Emergency Room:
  - To treat routine ailments
  - Because you have no regular physician
  - Because it is late at night (and the need for treatment is not sudden and serious)
- Ambulette

Emergency Air Ambulance

We will provide in-network coverage for air ambulance services when needed to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

- Your medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances, and the use of land transportation would pose an immediate threat to your health
- Services are covered to transport you from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for your treatment as determined by Empire, and use of land ambulance would pose an immediate threat to your health

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the amount that would be paid for land ambulance to that hospital. If the services are provided by an out-of-network provider you may be required to pay the difference between the reasonable and customary allowed amount and the total charges.

Emergency Land Ambulance

We will provide coverage for land ambulance transportation to the nearest acute care hospital, in connection with emergency room care or emergency inpatient admission, provided by an ambulance service, when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in

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

Benefits are not available for transfers of covered members between healthcare facilities.

Maternity Care and Reproductive Services

IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses for maternity and newborn care when you use in-network providers. That means you do not need to pay a co-payment when you visit the obstetrician. Furthermore, routine tests related to pregnancy, obstetrical care in the hospital or birthing center, as well as routine newborn nursery care are all covered 100% in-network.

For out-of-network maternity services, you pay the deductible, coinsurance and any amount above the allowed amount. Empire's reimbursements for the remaining balance may be consolidated in up to three installments, as follows:

- Two payments for prenatal care
- One payment for delivery and post-natal care

Whether services are provided in-network or out-of-network, call Empire's Medical Management Program at 1-800-982-8089 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

Your baby is automatically covered under the plan for the first 30 days if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have family coverage, call your employer within 30 days to add your newborn as a dependent.

MATERNITY CARE PROGRAM

Empire understands that having a baby is an important and exciting time in your life, so we developed the Maternity Care Program. Specially trained obstetrical nurses, working with you and your doctor, help you and your baby obtain appropriate medical care throughout your pregnancy, delivery and after your baby's birth. And just as important, we're here to answer your questions.

While most pregnancies end successfully with a healthy mother and baby, Empire's Maternity Care Program is also there to identify high-risk pregnancies. If necessary, Empire will suggest a network specialist to you who is trained to deal with complicated pregnancies. We can also provide home health care referrals and health education counseling.

Please let us know as soon as you know that you're pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in the Maternity Care Program. Call 1-800-845-4742 and listen for the prompt that says "precertify." You will be transferred to the Maternity Care Program.

Obstetrical care in the hospital or an in-network birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe (precertification is not required). The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later.
- Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician
- Parent education, and assistance and training in breast or bottle feeding, if available
- Circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother. Call Empire's Medical Management Program to precertify the hospital stay.
- Semi-private room

What's Not Covered

These maternity care services are not covered:

- Days in hospital that are not medically necessary (beyond the 48-hour/96-hour limits)
- Services that are not medically necessary
- Private room
- Out-of-network birthing center facilities
- Private duty nursing

REMEMBER	**Use a network obstetrician/gynecologist to receive the lowest cost maternity care.**

Infertility Treatment

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations. Following are covered services and limitations:

- Medical and surgical procedures, such as
  - artificial insemination
  - intrauterine insemination and
  - dilation and curettage (D&C), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility; and services in relation to diagnostic tests and procedures necessary
  - to determine infertility, or
  - in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered are:

    - hysterosalpingogram
    - hysteroscopy
    - endometrial biopsy
    - laparoscopy
    - sono-hysterogram
    - post-coital tests
    - testis biopsy
    - semen analysis
    - blood tests
    - ultrasound, and
    - other medically necessary diagnostic tests and procedures, unless excluded by law.

Services must be medically necessary and must be received from eligible providers as determined by Empire in accordance with applicable regulations of the New York State Insurance Department. In general, an eligible provider is defined as a health care provider who meets the required training, experience and other standards established and adopted by the American Society for Reproductive Medicine for the performance of procedures and treatments for the diagnosis and treatment of infertility.

If you have prescription drug coverage, then prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services are covered, subject to all the conditions, exclusions, limitations and requirements that apply to all other prescription drugs under this plan.

ADVANCED REPRODUCTIVE SERVICES

In addition to the above benefits for infertility, your health plan provides coverage for advanced reproductive technologies if you are infertile and unable to achieve a pregnancy through the use of other generally acceptable methodologies of treating infertility. All procedures must be performed by network physicians. For advanced reproductive technologies, network physicians must be members of, and contribute data to, the Society of Assisted Reproductive Technologies (SART).

Advanced reproductive technology services must be precertified by calling Empire's Medical Management Program at 1-800-982-8089 at least two weeks prior to starting treatment. If you do not call to precertify services, covered benefits may be denied or reduced 50% up to $2,500 per cycle.

Infertility as defined in regulations of the New York State Insurance Department means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse as further defined in the regulations.

WHAT'S COVERED

Following are covered services and limitations:

Medical and surgical procedures, such as

- Three (3) cycles of advanced reproductive technologies, including:
  - In-vitro Fertilization (IVF)
  - Zygote Intrafallopian Transfer (ZIFT)
  - Gamete Intrafallopian Transfer (GIFT)
  - Intracytoplasmic Sperm Injection (ICSI)

Cycles obtained before becoming a health plan member will count towards the three-cycle limitation. A cycle which is started but not completed is a dropped cycle. Dropped cycles, even if no transfer is performed, will count towards the number of cycles, as follows:

  - First covered cycle – 3 dropped cycles will count as the first cycle
  - Second covered cycle – 2 dropped cycles will count as the second cycle
  - Third covered cycle – 2 dropped cycles will count as the third cycle
- Medically necessary and appropriate diagnostic workup and radiology services
- Pathology and laboratory services including:
  - Hormonal assays
  - Swimup semen analysis as appropriate
  - Ultrasound exams
  - Fertilization and embryo culture
  - Ova retrieval
  - Embryo, gamete-zygote transfer

WHAT'S NOT COVERED

We will not cover any services related to or in connection with:

- Any procedure for which donated ova or donated sperm are used
- Embryo cryo preservation or fees associated with it.
- Fallopian tube ligations and vasectomy reversals.
- Costs associated with maternity services.
- Surrogacy and any fees associated with it.
- Experimental, investigational or obsolete procedures, as defined in the contract to which this rider is attached.
- Services requested which are not medically appropriate, including but not limited to ovarian failure or obesity wherein the chances of successful pregnancy are substantially diminished.
- Services not specifically listed as covered in this rider.
- Services rendered by non-participating providers, unless authorized by the Medical Management Program.

For members covered under this group plan, the new contract a member may convert to after termination of coverage may not contain these infertility benefits.

Hospital Services

IF YOU VISIT THE HOSPITAL

Your plan covers most of the cost of your medically necessary care when you stay at a network hospital for surgery or treatment of illness or injury. When you use an out-of-network hospital or facility, you pay the deductible and coinsurance, plus any amount above Empire's allowed amount.

You are also covered for same-day (outpatient or ambulatory) hospital services, such as chemotherapy, radiation therapy, cardiac rehabilitation and kidney dialysis. Same-day surgical services or invasive diagnostic procedures are covered when they:

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms,
- May require either local or general anesthesia,
- Do not require inpatient hospital admission because it is not appropriate or medically necessary, and
- Would justify an inpatient hospital admission in the absence of a same-day surgery program.

Remember to call Empire's Medical Management Program at 1-800-982-8089 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or surgical procedure, call Medical Management within 48 hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to $2,500 for each hospital admission or surgery that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

The medical necessity and length of any hospital stay are subject to Empire's Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the Health Management section for additional information.

If surgery is performed in a network hospital, you will receive in-network benefits for the anesthesiologist, whether or not the anesthesiologist is in the network.

When you use a network hospital, you will not need to file a claim in most cases. When you use an out-of-network hospital, you may need to file a claim.

Tips For Getting Hospital Care

- If your doctor prescribes pre-surgical testing (unlimited visits), have your tests done within seven days prior to surgery at the hospital where surgery will be performed. For pre-surgical testing to be covered, you need to have a reservation for both a hospital bed and an operating room
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient And Outpatient Hospital Care

What's Covered

Covered services are listed in Your Benefits at a Glance section. Following are additional covered services and limitations for both inpatient and outpatient (same-day) care:

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services, when pre-approved by Empire's Medical Management Program (your provider must call to precertify these services). You must call to precertify out-of-network MRIs/MRAs.

Inpatient Hospital Care

What's Covered

Following are additional covered services for inpatient care:

- Semi-private room and board when
  – The patient is under the care of a physician, and – A hospital stay is medically necessary.
- Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital

- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.

- Use of cardiographic equipment
- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery
- Reconstructive surgery for a functional defect which is present from birth
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment
- Facilities, services, supplies and equipment related to medically necessary medical care

Outpatient Hospital Care

What's Covered

Following are additional covered services for same-day care:

- Same-day and hospital outpatient surgical facilities
- Surgeons
- Surgical assistant if:
  - None is available in the hospital or facility where the surgery is performed, and
  - The surgical assistant is not a hospital employee
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.
- Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:
  - At home, when provided, supervised and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment are not covered
  - In a hospital-based or free-standing facility. See "hospital/facility" in the Definitions section.

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room. The additional cost cannot be applied to your deductible or coinsurance.
- Diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
- Services performed in the following:
  - Nursing or convalescent homes
  - Institutions primarily for rest or for the aged
  - Rehabilitation facilities (except for physical therapy)
  - Spas
  - Sanitariums
  - Infirmaries at schools, colleges or camps
- Any part of a hospital stay that is primarily custodial
- Elective cosmetic surgery or any related complications
- Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility. See "hospital/facility" in the Details and Definitions section.

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

- Same-day surgery not precertified as medically necessary by Empire's Medical Management Program
- Routine medical care including but not limited to:
  - Inoculation or vaccination
  - Drug administration or injection, excluding chemotherapy
- Collection or storage of your own blood, blood products, semen or bone marrow

Durable Medical Equipment and Supplies

IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

Your plan covers the cost of medically necessary prosthetics, orthotics and durable medical equipment from network suppliers only. In-network benefits and plan maximums are shown in Your *Benefits at a Glance section*. Out-of-network benefits are not available.

The network supplier must precertify the rental or purchase by calling Empire's Medical Management Program at 1-800-982-8089. When using a supplier outside Empire's operating area through the BlueCard PPO Program, *you* are responsible for precertifying services. An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-342-9816.

Disposable medical supplies, such as syringes, are covered up to the allowed amount whether you obtain them in- or out-of-network.

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both in- and out-of network. If you have prescription drug coverage with Empire Pharmacy Management℠, you may order these formulas or supplements through the Empire Pharmacy Management Program. Benefits and plan maximums are shown in Your *Benefits at a Glance* section.

Tip For Obtaining Special Medical Supplies

For prosthetics, orthotics and durable medical equipment, be sure the network vendor knows the number to call for Medical Management precertification.

What's Covered

Covered services are listed in Your Benefits At A Glance section. Following are additional covered services and limitations:

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
  - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
  - Prescription lenses, if organic lens is lacking
  - Supportive devices essential to the use of an artificial limb
  - Corrective braces
  - Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
- Rental (or purchase when more economical) of medically necessary durable medical equipment
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician
- Reasonable cost of repairs and maintenance for covered medical equipment
- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
  - The formula is medically necessary and effective, and
  - Without the formula, the patient would become malnourished, suffer from serious physical disorders or die.
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare provider must provide a written order.

What's Not Covered

The following equipment is not covered

- Air conditioners or purifiers
- Humidifiers or dehumidifiers
- Exercise equipment
- Swimming pools
- False teeth
- Hearing aids

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

You receive coverage through Empire's PPO for inpatient care in a skilled nursing facility or hospice. Benefits are available for network facilities only. Benefits and plan maximums are shown in Your *Benefits at a Glance* section.

In order to receive maximum benefits, please call 1-800-982-8089 to precertify skilled nursing with Empire's Medical Management Program.

Skilled Nursing Care

What's Covered

You are covered for inpatient care in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services. The number of covered days is listed in Your *Benefits at a Glance* section. Prior hospitalization is not required in order to be eligible for benefits. Services are covered if:

- The doctor provides:
  - A referral and written treatment plan,
  - A projected length of stay,
  - An explanation of the services the patient needs, and
  - The intended benefits of care.
- Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other healthcare professional.

What's Not Covered

The following skilled nursing care services are not covered:

- Skilled nursing facility care that primarily:
  - Gives assistance with daily living activities
  - Is for rest or for the aged
  - Treats drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

Hospice Care

Empire covers up to 210 days of hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

What's Covered

Covered services are listed in Your Benefits at a Glance section. Following are additional covered services and limitations:

- Hospice care services, including:
  - Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN)
  - Medical care given by the hospice doctor
  - Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference
  - Physical, occupational, speech and respiratory therapy when required for control of symptoms
  - Laboratory tests, X-rays, chemotherapy and radiation therapy
  - Social and counseling services for the patient's family, including bereavement counseling visits until one year after death
  - Transportation between home and hospital or hospice when medically necessary
  - Medical supplies and rental of durable medical equipment
  - Up to 14 hours of respite care in any week

Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.
- Empire's Medical Management Program will help direct you to a skilled nursing facility that provides the appropriate care. When selecting from among multiple facilities, you may want to consider:
  - Is the facility's location convenient to friends, relatives and doctors?
  - What size facility is most suitable? A large facility may have more activities; a smaller one may be more personal.
  - Are visiting hours convenient for friends and relatives?
  - Who directs your care? Does your doctor have privileges at the facility?
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

IF YOU NEED HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage when you use an in-network provider. For out-of-network home health care, you pay coinsurance only (the deductible does not apply.) Out-of-network agencies must be certified by New York State or have comparable certification from another state. Benefits and plan maximums are shown in Your *Benefits at a Glance* section.

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network.An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-342-9816.

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- Up to 365 home health care visits per year, combined in- and out-of-network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests

What's Not Covered

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care
- Out-of-network home infusion therapy

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

You receive benefits through Empire's plan for physical, occupational, speech and vision therapy. Outpatient physical, occupational, speech and vision therapy services are available in-network only. Inpatient physical therapy can be in-network or out-of-network.

Please call Empire's Medical Management Program at 1-800-982-8089 to precertify all physical, occupational, and speech therapy. This will ensure that you receive maximum benefits.

Tip for Receiving Therapy

- Ask for exercises you can do at home that will help you get better faster.

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an inpatient or outpatient basis up to the plan maximums if:
  - Prescribed by a physician,
  - Designed to improve or restore physical functioning within a reasonable period of time, and
  - Approved by Empire's Medical Management Program.

Outpatient care must be given at home, in a therapist's office or in an outpatient facility by an in-network provider; inpatient therapy must be short-term.

- Occupational, speech or vision therapy, or any combination of these on an outpatient basis up to the plan maximums if:
  - Prescribed by a physician or in conjunction with a physician's services
  - Given by skilled medical personnel at home, in a therapist's office or in an outpatient facility,
  - Performed by a licensed speech/language pathologist or audiologist, and
  - Approved by Empire's Medical Management Program, except vision therapy.

What's Not Covered

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities
- Tests, evaluations or diagnoses received within the 12 months prior to the doctor's referral or order for occupational, speech or vision therapy

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

At Empire we realize that your mental health is as important as your physical health. That's why we include behavioral healthcare benefits at little out-of-pocket cost. Your behavioral healthcare benefits cover outpatient treatment for alcohol or substance abuse both in-network and out-of-network, and inpatient detoxification in-network and out-of-network. Inpatient alcohol and substance abuse rehabilitation in a facility is covered in-network and out-of-network. Mental healthcare is covered on an inpatient basis in-network and out-of-network and on an outpatient basis in-network and out-of-network.

Please note that, with the exception of outpatient alcohol and substance abuse treatment, the coinsurance that you pay for out-of-network behavioral healthcare services will count toward reaching your annual out-of-pocket maximum.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance, except for the first twelve routine in-network outpatient visits each calendar year and outpatient mental health care on an out-of-network basis. When you call Member Services at 1-800-342-9816 to precertify in-network services, a customer service representative will connect you to a care manager, who can refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

As of January 1, 2008, no prior authorization is required for the first 12 routine outpatient visits each calendar year.

If you do not call to precertify behavioral healthcare, or if you call but do not follow their recommended treatment plan, covered benefits may be denied or reduced as follows:

- 50% up to $2,500 per inpatient admission for mental health or alcohol/substance abuse detoxification
- 50% for each outpatient mental health visit to an in-network provider
- 50% for each outpatient alcohol and substance abuse facility or provider visit
- 50% for each professional mental health care visit made during an inpatient stay

REMEMBER	**When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call Member Services at 1-800-342-9816 within 48 hours or as soon as is reasonably possible.** **If you want to know if a provider or facility is covered in-network, call Member Services and a customer service representative will connect you to a care manager, who can help you.** **If you do not agree with a certification decision made, you can file an appeal. For more information see "Appeals and Grievances" in the Details and Definitions section**

Mental Health Care

What's Covered

In addition to the services listed in Your *Benefits at a Glance* section, the following mental health care service is covered:

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management.
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Treatment in a New York State Health Department-designated Comprehensive Care Center for Eating Disorders pursuant to Article 27-J of the New York State Public Health Law.

What's Not Covered

The following mental health care services are not covered:

- Care that is not medically necessary

Treatment for Alcohol or Substance Abuse

What's Covered

In addition to the services listed in *Your Benefits At A Glance* section, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive medically necessary counseling visits.
- Out-of-network outpatient treatment at a facility that:
  - Has New York State certification from the Office of Alcoholism and Substance Abuse Services

– Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient's diagnosis.

What's Not Covered

The following alcohol and substance abuse treatment services are not covered

- Out-of-network outpatient alcohol or substance abuse treatment at a facility that does not meet Empire's certification requirements as stated above
- Care that is not medically necessary

Empire's Pharmacy Program

YOUR PHARMACY BENEFITS PROGRAM

Empire understands that filling prescriptions can be costly. To help reduce your costs, Empire offers the Pharmacy Management program. Your Empire pharmacy benefits program covers most drugs, as long as they have been prescribed by a physician and approved by the Federal Drug Administration (FDA). You can choose whether to fill your prescription at a network pharmacy or through the mail-order program.

FILLING A PRESCRIPTION

Empire understands that filling prescriptions can be costly. Therefore, Empire offers the Pharmacy Benefits Management program, to help reduce your costs. Your Empire pharmacy benefits program covers many drugs that have been approved by the Food and Drug Administration (FDA) if the drugs are medically necessary for the treatment of the condition, and you have a prescription from your physician or other licensed provider.

To receive the benefits of your pharmacy program, you must fill your prescription at a network pharmacy or through the mail-order program. To view or print a prescription drug mail order form go to **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Discounts and Savings.

You pay a co-payment or a co-payment plus an ancillary charge each time you fill your prescription at a network pharmacy. An ancillary charge is the price difference between the generic drug's allowed amount and the brand-name drug's price. Your out-of-pocket costs vary depending on whether the prescription is for a generic or brand-name drug. Using generic medicines, where appropriate, will help you to maximize your benefits.

EMPIRE'S DRUG FORMULARY

Empire's Drug Formulary is a list of covered prescription drugs recommended for use by Empire's Pharmacy and Therapeutics (P&T) Committee; composed of clinical pharmacists and independent physicians from various medical specialties. Empire's P&T Committee frequently review new and existing medications based on safety and how well they work, to ensure we meet the needs of our members and to include the newest medications as they become available. Empire's formulary includes generic and certain covered brand-name drugs.

One way we help you and your doctor choose prescription drugs that are clinically appropriate and cost effective is through the step therapy process. The P&T Committee reviews drugs for their safety, effectiveness and value. Based on their findings, the P&T Committee has recommended certain drugs as the first ones to try when starting or changing medication treatment. Trying drugs in this step-by-step fashion is called step therapy.

The use of the formulary is voluntary under your benefits program however you can obtain an up-to-date formulary by visiting **www.empireblue.com** or by calling your pharmacy benefit member service center at 1-800-839-8442.

PRIOR AUTHORIZATION

Certain prescription drugs require prior authorization review before filling. These drugs are identified on the formulary list as "PAR" (Prior Authorization Required) and must be approved by Empire before you fill the prescription. In some instances use of one or more drugs in a step-wise graduated manner for cost/quality reasons may be required first. You can view an up-to-date "PAR" drug listing by visiting **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Drug Information or by calling Member Services at the telephone number listed on your card. Your physician or pharmacist can request this authorization by calling Empire Pharmacy Services at 1-800-839-8442.

QUANTITY LIMITS

Some drugs have quantity limits. They are indicated by the letters "QL" (Quantity Limit) and require authorization only if a prescription is written for more than the monthly allowed amount. You can view quantity limits by going to **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Drug Information. Some of the drugs requiring any of these actions are noted on the formulary list. If the quantity is approved, it will be covered.

REMEMBER	**Benefits are available for prescriptions filled at network pharmacies.**

NETWORK PHARMACY

You must fill a prescription at an Empire network pharmacy for up to a 30-day supply of FDA-approved drugs, if prescribed by a physician or other licensed provider. Empire Pharmacy Management offers:

- **Low cost**. You can receive up to a 30-day supply for each drug for a single co-payment.

- **Convenience**. You must present your Empire ID card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program.

NON-NETWORK PHARMACY

A non-participating pharmacy is one which does not have an agreement with Empire. You must pay the pharmacy and then you must submit a claim form and receipt to us which verifies that the prescription was filled. We will then pay you the lower of the actual charge of the amount listed in the "Maximum Allowable Cost List", less the co-payment. The "Maximum Allowable Cost List" is a list of prescription drugs that will be covered at a generic product level established by us. This list is subject to periodic review and modified by us. You must pay the difference between our payment and the actual charge. Brand name prescription drugs for which there are no generic equivalents shall be reimbursed at the actual charge, less the co-payment.

Tip for Using a Network Pharmacy

To locate a network pharmacy, check the list of national chain pharmacies you received with your I.D. card. For information about network pharmacies that are not a part of a national chain, log on to ***www.empireblue.com*** and click on the Rx icon on your home page or call Empire Pharmacy Management at 1-800-342-9816. You can also call when you are away from home for the name and location of the nearest participating pharmacy.

REMEMBER	**A pharmacist is not required to fill a prescription that in the pharmacist's professional judgment should not be filled.**

MAIL ORDER CHRONIC DRUG PROGRAM

If your prescription is filled through our Mail Order Chronic Drug Program, we will pay the entire cost of the prescription or refill, after a $1.00 co-payment for a six month supply. The chronic drug must require a prescription in order to be dispensed and it must be prescribed by your Doctor. A chronic drug is a drug which is: an antiarthritic; an anticoagulant; a cardiac drug; a hormone; a thyroid preparation; insulin; or any other drug we place on a list of chronic drugs available under this section.

SAVE MONEY, UP TO 33%, WITH EMPIRE'S MAIL-ORDER PRESCRIPTION SERVICE

You can reduce your drug co-payments by using Empire's pharmacy mail-order service because you can receive up to a 180-day (six-month) supply of your medication on a single prescription for only one co-payment. This service is ideal for members who take the same medication on an on-going basis.

The same prescriptions filled at a participating pharmacy cost three co-payments for a three-month supply of medication—one co-payment for each 30-day supply.

How to Order Your Prescription by Mail

- Ask your doctor to write a prescription for each of your medication(s)
- Complete the mail order form you received in the mail with your ID card(s). You can get additional forms by going to ***www.empireblue.com*** or calling Empire Pharmacy Management at the number on the back of your member ID card.
- Place your order for a refill at least three weeks before your current supply will run out.
- You will receive your filled prescription at your home within 14 working days, postage paid. If you prefer, you can also choose faster shipping for an additional fee

Tips for Using Mail Order

- The first time you fill a prescription through mail order, ask your physician for a second prescription for a three-week supply. You can fill the second prescription at a local pharmacy so you have the medication until the mail order is processed.
- Place your order for a refill at least three weeks before your current supply will run out.

MANAGE YOUR PHARMACY PLAN ONLINE

Taking care of your pharmacy needs is easier than ever with Empire's online pharmacy. If you're registered for Online Member Services, just go to ***www.empireblue.com*** where you can:

- Search Empire's drug formulary for a particular drug (by name or therapeutic category)
- Locate a participating retail pharmacy near where you live or work
- Order prescription refills through the mail order program
- Research usage instructions, drug interactions and side effects for thousands of medications
- Simply log on to our website and access your own personal secure home page. Click on "My Pharmacy Plan" which is right next to the Rx symbol under "Your Health Plan."

Empire Pharmacy Management Customer Service: 1-800-342-9816

What's Covered

The following prescription drugs are covered:

- Insulin and self-administered injectables
- Diabetic supplies
- Enteral formulas for home use that are medically necessary and proven effective for the specific disease when prescribed by a written order by a physician or other health care provider licensed to prescribe under applicable law
- Nutritional supplements when medically necessary and proven effective for treatment
- Infertility drugs
- Contraceptive drugs or devices and diaphragms
- Bone mineral density drugs and devices
- Refills for up to one year from the date of the original prescription, if authorized by the physician and indicated on the prescription
- Smoking cessation products, by prescription only

What's Not Covered

The following items are not covered:

- Drugs or devices that do not require a prescription or are available over the counter, except insulin and diabetic supplies
- Devices of any type, such as therapeutic devices, artificial appliances, hypodermic needles, syringes or similar devices, except where specifically covered, and except for bone density testing and treatment devices
- Charges or fees for drug administration or injection
- Vitamins that by law do not require a prescription
- Investigational or experimental drugs (i.e., medications used for experiments and/or dosage levels determined by Empire to be experimental) Refer to the Exclusions and Limitations Section and also the Complaints, Appeals and Grievances Section.
- Drugs received while in a hospital, nursing home or other facility (covered under medical plan as indicated)
- Appetite suppressants, unless medically necessary
- Compounded medications with no ingredients that require a prescription
- Medications for cosmetic purposes only
- Medications not approved by the FDA, unless otherwise required by law (i.e., drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA and not considered investigational or experimental)
- Replacement of lost, stolen or damaged prescription medications
- The cost for medication in excess of plan limits
- Refills not dispensed in accordance with the prescription
- Refills beyond one year from the original prescription date

Vision Care

IF YOU NEED VISION CARE

Empire recognizes that good vision is part of good health, so we offer vision care coverage. You receive vision care benefits only when you use network providers. There are no out-of-network benefits for vision care. To find a participating provider in your area, simply call 1-877-923-2847 between 8:00 a.m. and 8:00 p.m. weekdays, 9:00 a.m. and 4:00 p.m. Saturdays. Then contact the provider to make an appointment. Benefits are paid in full when you use a network provider, subject to the co-payments shown below.

VISION CARE SERVICES	CO-PAYMENT
EYE EXAM	$5
FRAMES (limited selection)*	$10
PREMIER FRAMES	$40
SOFT CONTACT LENSES – PER PAIR (STANDARD DAILY WEAR) **	$25
SINGLE VISION, BIFOCAL OR TRIFOCAL LENSES	$0
PROGRESSIVE ADDITIONAL LENSES	$80
BLENDED SEGMENT LENSES	$20
PHOTOCHROMIC OR SUPERSHIELD SINGLE VISION LENSES	$15
PHOTOCHROMIC OR SUPERSHIELD MULTIFOCAL VISION LENSES	$25
ULTRAVIOLET COATING	$10
REFLECTION-FREE COATING	$33
POLAROID LENSES	$60
POLYCARBONATE LENSES	$30
HIGH INDEX LENSES	$55
TRANSITION LENSES	$70

What's Covered

Vision care benefits include one comprehensive eye exam, subject to a $5 co-payment and a select group of eyewear (frames with corrective lenses or contact lenses) every 24 months for each covered member. Eye exams must be conducted in a single visit. If you purchase eyewear, you must buy it from the same Network Provider who did the examination.

What's Not Covered

The following vision care services are not covered:

- Treatment of eyes and eye disease, including ophthalmologic care (covered under your medical plan)
- Replacement of lost, stolen, broken or duplicate eye wear
- Eye examinations required by an employer
- More than one eye exam and set of eyewear per person in each 24-month period
- Corrective eye surgery for near/far sightedness (i.e. PRK, LASIK)
- Special procedures such as orthoptics training

*In addition, vision care benefits include a $35 allowance for non-plan frames.

** In addition, vision care benefits include a $75 allowance for non-plan soft contact lenses.

Exclusions and Limitations

EXCLUSIONS

In addition to services mentioned under "What's Not Covered" in the prior sections, your plan does not cover the following:

Dental Services

- Dental services, including but not limited to:
  - Cavities and extractions
  - Care of gums
  - Bones supporting the teeth or periodontal abscess
  - Orthodontia
  - False teeth
  - Treatment of TMJ that is dental in nature
  - Orthognathic surgery that is dental in nature

However, your plan does cover:

- Surgical removal of impacted teeth
- Treatment of sound natural teeth injured by accident if treated within 12 months of the injury

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
  - Experimental or investigative
  - Obsolete or ineffective
- Any hospitalization in connection with experimental or investigational treatments. "Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:
  - Not of proven benefit
  - Not generally recognized by the medical community (as reflected in published medical literature)

Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer. Once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met.
- Published peer review medical literature must conclude that the technology has a definite positive effect on health outcomes.
- Published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state. *Refer to the Complaints, Appeals and Grievances Section.*

Government Services

- Services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
  - Specific services covered in a special agreement between Empire and a government hospital
  - United States Veterans' Administration or Department of Defense Hospitals, except services in connection with a service-related disability. In an emergency, Empire will provide benefits until the government hospital can safely transfer the patient to a participating hospital.

Home Care

- Services performed at home, except for those services specifically noted elsewhere in this Guide as available either at home or as an emergency.

Inappropriate Billing

- Services usually given without charge, even if charges are billed
- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified

Medically Unnecessary Services

- Services, treatment or supplies not medically necessary in Empire's judgment. See Definitions section for more information.

Miscellaneous

- Surgery and/or treatment for gender change

Prescription Drugs

- All over the counter drugs, vitamins, appetite suppressants, or any other type of medication, unless specifically indicated.

Sterilization

- Reversal of elective sterilization, including vasectomies and tubal ligations

Travel

- Travel, even if associated with treatment and recommended by a doctor

War

- Services for illness or injury received as a result of war

Workers' Compensation

- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs

LIMITATION AS INDEPENDENT CONTRACTOR

The relationship between Empire BlueCross BlueShield and hospitals, facilities or providers is that of independent contractors. Nothing in this contract shall be deemed to create between Empire and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Empire will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

Health Management

Empire's Medical Management Program

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the plan will pay. To help you manage your health, Empire provides the Empire's Medical Management Program, a service that precertifies hospital admissions and certain treatments and procedures, to help ensure that you receive the highest quality of care for the right length of time, in the right setting and with the maximum available coverage.

Empire's Medical Management Program works with you and your provider to help confirm the medical necessity of services and help you make sound health care decisions. The program helps ensure that you and your family members receive the highest quality of care at the right time, in the most appropriate setting.

You can contact our Medical Management program by calling the Member Services telephone number located on the back of your identification card.

How Empire's Medical Management Program Helps You

To help ensure that you receive the maximum coverage available to you, Empire's Medical Management Program

- Reviews all planned and emergency hospital admissions.
- Reviews ongoing hospitalization.
- Performs case management.
- Coordinates discharge planning.
- Coordinates purchase and replacement of durable medical equipment, prosthetics and orthotic requirements.
- Reviews inpatient and ambulatory surgery.
- Reviews high-risk maternity admissions.
- Reviews care in a hospice or skilled nursing or other facility.

All other services will be subject to retrospective review by our Medical Management team to determine medical necessity.

The following health care services must be precertified with Empire's Medical Management Program.

CALL TO PRECERTIFY THE REQUIRED SERVICES…
FOR ALL HOSPITAL ADMISSIONS • At least two weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission, or as soon as reasonably possible • Of newborns for illness or injury • Before you are admitted to a rehabilitation facility or a skilled nursing facility
MATERNITY CARE • As soon as reasonably possible; we request notification within the first three months of pregnancy when possible • Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth.
BEFORE YOU RECEIVE/USE • For Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification • Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs • Outpatient treatment for Mental Health Care and Substance Abuse Care • Occupational, physical and speech therapy • Outpatient/ Ambulatory Surgical Treatments (certain procedures) • High tech radiology services: MRI, MRA, PET, CAT, CTA, MRS, CT/PET, SPECT, ECHO Cardiology, Nuclear Technology services • Diagnostics • Outpatient Treatments • Durable medical equipment, prosthetics, orthotics • Occupational, Vision and Speech Therapy • Chiropractic care* • Air ambulance

*** Empire's Medical Management Program must be contacted to determine medical necessity of all chiropractic care after the fifth visit. We will not pay for any visits, which we determine were not medically necessary, in accordance with your benefit Certificate.**

IF SERVICES ARE NOT PRECERTIFIED

Failure to comply with the Medical Management Program requirements set forth in your Benefit Contract will result in penalties or denial of benefits. Please refer to "RIDER TO YOUR CONTRACT OR CERTIFICATE REGARDING PRECERTIFICATION AND PRIOR AUTHORIZATION REQUIREMENTS" of the Benefit Contract for more information.

INITIAL DECISIONS

Empire will comply with the following time frames in processing precertification, concurrent and retrospective review of requests for services.

- ***Precertification Requests.*** Precertification means that Empire's Medical Management Program must be contacted for approval before you receive certain health care services that are subject to precertification. We will review all non-urgent requests for precertification within three (3) business days of receipt of all necessary information but not to exceed 15 calendar days from the receipt of the request. If we do not have enough information to make a decision within 15 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal to denial of coverage decision.
- ***Urgent Precertification Requests.*** If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision, we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- ***Concurrent Requests.*** Concurrent review means that Empire reviews your ongoing care during your treatment or

hospital stay to be sure you get the right care in the right setting and for the right length of time. When the request to continue care is received at least 24 hours before the last approved day, we will complete all concurrent reviews of services within 24 hours of our receipt of the request.

- ***Retrospective Requests.*** Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal the denial of coverage decision. If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

IF A REQUEST IS DENIED

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, or because the service has been determined to be experimental or investigational Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. See section in this booklet titled "Complaints, Appeals and Grievances" for more information.

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Healthy Living Programs

PREVENTIVE CARE

Preventive care is an important and valuable part of your healthcare. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why Empire provides many preventive care services for free or only a small co-payment when you use network providers.

For more information on staying healthy, be sure to check the My Health section of *www.empireblue.com*. There you'll find the latest information on hundreds of topics ranging from nutrition to stress management to children's immunization guidelines.

Tips For Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one.
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations.

What's Covered

Covered services are listed in Your *Benefits at a Glance* section. Following are additional covered services and limitations:

- Well-woman care visits to a gynecologist/obstetrician
- Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:

  For individuals who are:
  - Ages 55 through 65 - 1 baseline
  - Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
  - Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

  For individuals who meet the criteria of the above programs, including one or more of the following:
  - Previously diagnosed with or having a family history of osteoporosis
  - Symptoms or conditions indicative of the presence or significant risk of osteoporosis
  - Prescribed drug regimen posing a significant risk of osteoporosis
  - Lifestyle factors to such a degree posing a significant risk of osteoporosis
  - Age, gender and/or other physiological characteristics that pose a significant risk of osteoporosis.
- Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.
- Well-child care immunizations as listed:

  - DPT (diphtheria, pertussis and tetanus)
  - Polio
  - MMR (measles, mumps and rubella)
  - Varicella (chicken pox)
  - Hepatitis B Hemophilus
  - Tetanus-diphtheria
  - Pneumococcal
  - Meningococcal Tetramune
  - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

What's Not Covered

These preventive care services are not covered:

- Screening tests done at your place of work at no cost to you
- Free screening services offered by a government health department
- Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests

360° Health® – Empire's Health Services Programs

EMPIRE'S HEALTH SERVICES PROGRAM, 360º HEALTH®, HELPS YOU IMPROVE, MANAGE AND MAINTAIN YOUR HEALTH.

No matter what your healthcare needs, as an Empire plan member you have access to programs and services to help you achieve and maintain your highest potential for good health —at no additional charge. 360º Health is a group of programs that surround you with personalized support. From preventive care to managing complex conditions, we are there when you need us.
Empire's 360° Health is organized into:

- Online health and wellness resources.
- Discounts on health-related products & services, and alternative therapies
- Guidance and support for when you need help
- Condition management for those with chronic health issues.

The following are descriptions of some of the programs and services available to you:

24/7 NurseLine and AudioHealth Library – receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call 1-877-Talk-2-RN (1-877-825-5276). If you need advice on comforting a baby in the middle of the night or need to locate a doctor, we'll be there. Call us to:

- Assess and understand your symptoms.
- Find additional help to make informed healthcare decisions.
- Locate a doctor, hospital or other practitioner.
- Get information about an illness, medication or prescription.
- Find information about a personal health issue such as diet, exercise or high blood pressure
- Answer questions on pregnancy
- Get assistance with discharge from a hospital
- Help you decide if a medical situation requires emergency treatment.

You can also access an easy-to-use audio library. You'll hear advice and news delivered in English and Spanish on several topics — from colds and sore throats to diabetes and cancer. Please refer to the back of this booklet for a list of recorded topics.

24/7 NurseLine is not for emergencies, so please do not call if you believe you or a family member

- Is having a heart attack or stroke
- Is severely injured
- Is unable to breathe
- May have ingested poisonous or toxic substances
- Is unconscious.

In these cases, call 911 or your local emergency service as soon as possible.

Here's how to use 24/7 NurseLine:

- Dial 1-877-Talk-2-RN (1-877-825-5276) and follow the prompts to speak with a nurse or listen to the audiotape messages.
- If you plan on listening to the tapes, have your member ID number handy. You will need to enter the first three digits. For example, if your number is YLD123456789, enter YLD (123). For members who don't speak English, stay on the line to be connected to an interpreter.
- The back of this booklet contains a complete listing of audiotape messages. Note the code number to the right of the topic(s) that you want to listen to, as you will be prompted for the number.
- If you have additional questions after listening to a tape, simply connect to the on-duty nurse.

SpecialOffers – Members can receive discounts on alternative medicine therapies and other health services. Go to the "Members" section of *www.empireblue.com*, look under Health Information, then select "360º Health", and click on *"SpecialOffers"*. You can get access to discounts for services and products such as:

- Services by Alternative Practitioners
- Wellness Products
- Fitness Club Membership
- Vision Services
- Weight Loss Programs

Please note that these services and products may not be available to your group and in all states, and are not covered benefits under your Empire healthcare plan. Empire makes no payment for these value-added programs available to you. Members pay the full amount of the provider's discounted fee.

Empire does not endorse or warrant these discounted services and products in any way. Empire reserves the right to change, amend or withdraw any and all discount programs or services at any time without notice to any party.

Member Newsletter – Our semi-annual member newsletter, *HealthySolutions*, contains a variety of articles on staying healthy **and** coping with chronic diseases such as diabetes and asthma as well as helpful information about your health plan.

Preventive HealthcareGuidelines – Distributed both in our member newsletter and available online at *www.empireblue.com*, these guides can help you and your family stay up-to-date on check-ups, immunizations, screenings and tests throughout every stage of your life.

My Health, powered by WebMD – this vast one-stop resource center of health information, services and tools is accessible to all eligible members through Member Online Services at *www.empireblue.com*. You'll be able to find out if you are at risk for certain conditions, access the latest in health news, learn about treatments for common conditions and diseases, and much more. You'll also find preventative healthcare guidelines including the important tests to take and discuss with your doctor. Topics include an online fitness program, LEAP (Lifetime Exercise Adherence Program), where you can create your own personal fitness routine; Ready, Set, Stop!, a smoking cessation program that blends conventional smoking cessation techniques with an interactive experience; and the Nutrition Center, where you can increase your understanding of your diet and find ways to improve its nutritional value.

Here's how to get to "My Health":

- Go to *www.empireblue.com.*
- Register or log on to Member Online Services.
- Click on "My Health" at the top of the screen.

Condition Management Programs – Created to give members a better understanding of their specific health condition, these voluntary programs help members manage their symptoms and become more self-reliant in order to lead healthier, more active lives. Members learn the importance of following their doctor's treatment plan, and by developing emergency plans they can feel independent and more empowered. All programs are completely voluntary. The level of interaction is based upon the severity of each member's condition and their individual need for assistance.

Currently there are 7 programs covering asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease, impact conditions, chronic kidney disease, heart failure and rare and chronic diseases.

Details and Definitions

In this section, we'll cover the details you need to know to make the plan work for you. Use it as a reference to understand:

- Who is eligible for coverage under your plan
- How to file a claim and get your benefits paid
- Your rights to appeal a claim payment or Medical Management decision
- What we mean by certain healthcare terms

Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit *www.empireblue.com* or call Member Services at 1-800-342-9816.

Eligibility

WHEN ARE YOU ELIGIBLE?

Your coverage under Empire's plan begins on:

- Your group's effective date; or
- On the date you are eligible for group benefits as a new employee as determined by your employer.

Contact your Benefits Administrator for more information on eligibility rules.

ELIGIBLE DEPENDENTS

The following family members are eligible for coverage under your plan:

- Your spouse (a partner to a marriage legally recognized in the jurisdiction in which it is performed)
- Your children (including stepchildren)
  - Until the end of the month in which each child reaches age 26
- Your unmarried children, regardless of age, who are physically or mentally disabled as defined by New York Mental Hygiene Law, provided the condition started before the age when coverage would have normally ended. Empire will require that a physician certify the child's condition.

Your plan does not cover foster children.

In addition to the dependent eligibility criteria above when your adult dependent reaches age 26 you will have the right to purchase coverage for the dependent up through age 29 under the Young Adult Election if the dependent meets the eligibility criteria for the option as provided under the New York State Age 29 law.

COVERAGE CATEGORY

Your coverage category indicates how many people your plan covers. You may choose:

- Individual, which covers only you
- Family, which covers you and one or more of the following:
  - Your spouse
  - Unmarried dependent children (natural or adopted)

ADDING OR REMOVING A DEPENDENT

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are:

- Having a baby
- Getting married
- Getting divorced (Spousal coverage ends on the last day of the month following a divorce or annulment.)
- Having your children reach the age limit for coverage, cease to be dependent on you or get married

If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the group's open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage under this Certificate within 60 days after the qualifying event.

Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.

If you or your eligible dependents reject initial enrollment, you and your eligible dependents can become covered for this program as follows:

- The member or eligible dependent was covered under another plan at the time coverage was initially offered, or
- Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
- Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one of the following:
  - Termination of employment
  - Termination of the other plan
  - Death of the spouse
  - Legal separation, divorce or annulment
  - Reduction in the number of hours of employment; or
- Contract holder contributions toward the premium payments for the other plan were terminated

Coverage must be applied for within 60 days of termination for one of the reasons described above.

If you marry and transfer to family coverage within 60 days of the marriage date, Empire will provide retroactive coverage during this period. Otherwise, coverage begins on the date Empire receives and accepts your completed enrollment form from your employer during the open enrollment period.

A newborn natural baby or an adopted baby in certain circumstances (see below) will automatically be covered under the plan if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have family coverage but notify Empire in writing within 60 days to change to family coverage, Empire will provide retroactive coverage during this period. Otherwise, coverage will begin on the date Empire receives your notice of election form from your employer during the open enrollment period.

An adopted newborn is covered from the moment of birth if:

- You take custody as soon as the infant is released from the hospital after birth,
- The newborn is dependent upon you pending finalization of the adoption, and
- You file an adoption petition with New York State within 30 days of the infant's birth.

Adopted newborns will not be covered from the moment of birth if:

- The infant has coverage from one of the natural parents for the newborn's initial hospital stay
- A notice revoking the adoption has been filed
- One of the natural parents revokes their consent to the adoption

Please refer to the back of this benefit booklet for the rider regarding amended requirements for enrolling a newborn child.

Qualified Medical Child Support Orders (QMCSO). A court order, judgment or decree that:

- Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or
- Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not the group health plan participant

You may request, without charge, the procedures governing the administration of a Qualified Medical Child Support Order or a Qualified Domestic Relations Order determinations from your Plan Administrator (generally the Employer/Sponsor of the group health plan. Your Plan Administrator will notify Empire to process the enrollment for the covered person.

Claims

IF YOU NEED TO FILE A CLAIM

Empire makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received out-of-network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	Provider files claim with Empire or local Blue Cross/Blue Shield plan*
MEDICAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire
AMBULANCE CHARGES	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire

- At some out-of-area and non-participating hospitals, you may have to pay the hospital's bill. If this happens, include an original itemized hospital bill with your claim.

Send completed forms to:

Hospital Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Institutional Claims Department

Medical Claims:

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Medical Claims Department

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting *www.empireblue.com*.

Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-800-342-9816 to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

REMEMBER	**File claims within 18 months of the date of service to receive benefits!**

IF YOU HAVE MEDICAL COVERAGE UNDER TWO PLANS (COORDINATION OF BENEFITS – COB)

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other plan.

Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how Empire determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.
  - If the parent with custody is remarried, his or her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire Is the Secondary Plan

If the Empire plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

If You Receive An Overpayment Of Benefits

If you receive benefits that either should not have been paid, or are more than should have been paid, you must return any overpayment to Empire within 60 days of receiving it. Overpayments include:

- Payment for a service not covered by the plan
- Payment for a person not covered by the plan
- Payment that exceeds the amount due under your plan
- Duplicate payments for the same services

SUBROGATION

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident or due to medical malpractice, and we pay or provide benefits as a result of that injury or illness, we will be subrogated and succeed to your right of recovery against the party responsible for your illness or injury to the extent of the benefits we have paid or for the reasonable value of the services provided under your health care plan (the "benefits"). This means that we have the right independently of you, to proceed against the party responsible for your injury or illness to recover the benefits we have paid or provided.

In addition, we are also entitled to be reimbursed for the benefits we have paid or provided from a settlement or a judgment you receive from the party responsible for your illness or injury to the extent the settlement or judgment received from a third party specifically identifies or allocates monetary sums directly attributable to expenses for which we paid or provided benefits.

DUTY TO COOPERATE WITH US – POSSIBLE PENALTIES FOR FAILURE TO COOPERATE

You must cooperate with us in proceeding against the party responsible for your illness or injury to recover the benefits we have paid or provided. We will pay all expenses associated with a legal action instituted by us.

If you fail to cooperate with us in an action we bring against the party responsible for your illness or injury to recover the benefits we have paid or provided, the following penalty will apply: You will be responsible to repay to us the amount of

the benefits we have paid or provided. We agree to invoke this penalty only when your illness or injury caused by the third party results in our expenditure on your behalf of an amount exceeding $500 under this coverage.

Health Care Fraud

Illegal activity adds to everyone's cost for healthcare. That's why Empire welcomes your help in fighting fraud. If you know of any person receiving Empire benefits that they are not entitled to, call us. We will keep your identity confidential. Want to see some recent examples of Empire's fraud prevention efforts? Visit *www.empireblue.com.*

REMEMBER	**FRAUD HOTLINE 1-800-I.C.FRAUD (423-7283) During normal business hours**

If You Have Questions About a Benefit Payment

Empire reviews each claim for appropriate services and correct information before it is paid. Once a claim is processed, an Explanation of Benefits (EOB) will be sent directly to you if you have any responsibility on the claim other than your co-payment amount or if an adjustment is performed on your claim.

If Empire reduces or denies a claim payment, you will receive a written notification or an Explanation of Benefits (EOB) citing the reasons your claim was reduced or denied.

The notification will give you:

- The specific reason(s) for the denial
- References to the pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for you to establish the claim and an explanation of why this material or information is necessary
- An explanation of claims review procedures

If you have any questions about your claim, your Benefits Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-800-342-9816 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your claim. Send written inquiries to:

Empire BlueCross BlueShield
PPO Member Services
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Complaints, Appeals and Grievances

COMPLAINTS

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the healthcare services your plan offers, plan procedures or our customer service, call Member Services. Member Services may ask you to put your complaint in writing if it is too complex to handle over the telephone.

Empire BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services

If your complaint concerns behavioral healthcare, call 1-800-635-6626 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

We will resolve complaints within the following time frames:

- *Standard complaints*. Within 30 days of receiving all necessary information.
- *Expedited complaints*. Within 72 hours of receiving all necessary information.

If you are not satisfied with our decision on your complaint, you may file a grievance under the procedures described in the pages that follow.

Provider Quality Assurance

Because your healthcare is so important, Empire has a Quality Assurance Program designed to ensure that our network providers meet our high standards for care. Through this program, we continually evaluate our network providers.

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint at the above address. Empire will refer complaints about the clinical quality of the care you receive to the appropriate clinical staff member to investigate.

We also encourage you to send suggestions to Member Services for improving our policies and procedures. If you have any recommendations on improving our policies and procedures, please send them to the above address.

Your Right to Appoint a Representative

You may appoint a representative to act on your behalf if you are not able to submit a complaint, grievance or appeal on your own. Call Member Services for a form. When completed forms are returned, we will note the name of your representative's name on our files.

STANDARD INTERNAL APPEALS

An appeal is a request to review and change an adverse determination (i.e., denied authorization of a service) made by Empire's Medical Management Program or Behavioral Health Management Program that a service is not medically necessary or is excluded from coverage because it is considered experimental or investigational.

Appeals may be filed by telephone or in writing.

Level 1 Appeals

A Level 1 Appeal is your first request for review of the initial reduction or denial of services. You have 180 calendar days from the date of the notification letter to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge receipt of your appeal in writing within 15 calendar days from the initial receipt date.

Qualified clinical professionals who did not participate in the original decision will review your appeal.

We will make a decision within the following timeframes for 1st Level Appeals.

- *Precertification.* We will complete our review of a precertification appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Concurrent.* We will complete our review of a concurrent appeal (other than an expedited appeal) within 15 calendar days of receipt of the appeal.
- *Retrospective.* We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

We will provide a written notice of our determination to you or your representative, and your provider, within two business days of reaching a decision.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal, and/or the right to file an External Appeal through the New York State Department of Insurance. If Empire's Medical Management Program does not make a decision within the appropriate timeframe listed above, Empire will approve the service.

REMEMBER	**A Level 1 Appeal submitted beyond the 180-calendar-day limit will not be accepted for review. A Level 2 Appeal submitted beyond the 60-business-day limit will not be accepted for review.**

Expedited Level 1 Appeals

You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue healthcare services, procedures or treatments that have already started
- You need additional care during an ongoing course of treatment
- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Appeals may be filed by telephone and in writing.

When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum time frames:

- You or your provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 48 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you may request an external review by a New York State Department of Insurance appeals agent. For more details see the explanation of External Appeals. If Empire's Medical Management Program does not make a decision within the appropriate timeframe listed above, Empire will approve the service.

Level 2 Appeals and Timeframes

If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 business days from the receipt of the notice of the letter denying your Level 1 Appeal. If the appeal is not submitted within that timeframe, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone and in writing.

We will make a decision within the following timeframes for 2nd Level appeals:

- *Precertification.* We will complete our review of a precertification appeal within 15 calendar days of receipt of the appeal.
- *Concurrent.* We will complete our review of a concurrent appeal within 15 calendar days of receipt of the appeal.
- *Retrospective.* We will complete our review of a retrospective appeal within 30 calendar days of receipt of the appeal.

EXTERNAL APPEALS

You may also request an external review by a New York State Department of Insurance appeals agent. You can file an external appeal if benefits were denied:

- For lack of medical necessity
- Because the service was determined to be an experimental and/or investigational procedure

External appeals can also substitute for a Level 1 Appeal with Empire if you and Empire jointly agree to waive Empire's internal appeal process and proceed directly to the external appeal process.

To Obtain An External Appeal

You will receive an external appeal application when you receive the adverse determination from Empire regarding your Level 1 Appeal. For more information or an appeal application, contact one of the following:

- The New York State Department of Insurance at 1-800-400-8882 or *www.ins.state.ny.us*
- Empire Member Services at 1-800-342-9816.

Resolving an External Appeal

A New York State Department of Insurance appeal agent will review your request and decide if the denied service is medically necessary and should be covered by Empire. The agent's decision is final and binding on both your and Empire.

The application will provide clear instructions for completion. Empire does not charge a fee for the filing of an external appeal. Send your external appeal application to the New York State Department of Insurance, as stated on the form. Do not send the application to Empire. You and your doctor must release all pertinent medical information about your medical condition and request for services.

Submit your appeal within 45 calendar days:

- From the date you received the adverse determination from the Level 1 internal appeal.
- From the date that you and Empire agree to waive Empire's internal appeals process.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level internal plan appeal or the date Empire agreed to waive the internal appeal process.

If you have any questions regarding external appeals, please call Empire's Medical Management Program at 1-800-553-9603. Note that the number only responds to inquiries about external appeals.

Standard External Review Process

Standard external appeals will be decided according to the following timeframes:

- An external appeal agent must decide an external standard appeal within 30 calendar days of receiving your application for an external appeal.
- Five additional business days may be added if the agent needs additional information.
- If the agent determines that the information submitted is materially different from that considered by the plan, the plan will have three additional days to reconsider or affirm its decision.
- You and the plan will be notified within two business days of the external review agent's decision.

Expedited External Appeals

An expedited external appeal may be requested if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. In this case, the following timeframe applies:

- The agent will make a decision within three calendar days.
- Every reasonable effort will be made by the agent to notify you and Empire within two business days by telephone or fax. A written notice will also be sent immediately by the agent.

LEVEL 1 GRIEVANCES

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity. The types of decisions that may be reviewed through the grievance process include denials of a request for a referral to an out-of-network provider, benefit denials based on a specific limitation in the subscriber contract (e.g., no pre-certification was obtained), and complaint decisions where the member disagrees with Empire's findings.

If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance and a description of any additional information required to complete the review.

We will make a decision within the following timeframes for 1st Level Grievances:

- *Pre-service (services have not yet been rendered)*. We will complete our review of a pre-service grievance (other than an expedited grievance) within 15 calendar days of receipt of the grievance.
- *Post-service (services have already been rendered)*. We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

LEVEL 2 GRIEVANCES

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Empire. Empire must receive your request for a Level 2 Grievance by the end of the 60th business day after you receive our notice of determination on your Level 1 Grievance. If the Level 2 Grievance is not submitted within that timeframe, we will not review it and the decision on the Level 1 Grievance will stand. We will acknowledge receipt of the 2nd Level Grievance within 15 days of receiving the grievance. The written acknowledgement will include the name, address and telephone numbers of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the Level 1 Grievance decision will review the Level 2 Grievance.

We will make a decision within the following timeframes for 2nd Level Grievances:

- *Pre-service*. We will complete our review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- *Post-service*. We will complete our review of a post-service grievance within 30 calendar days of receipt of the grievance.

EXPEDITED GRIEVANCES

You can file an expedited Level 1 or Level 2 Grievance and receive a quicker response if a delay in resolution of the grievance would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Expedited Grievances may be filed by telephone and in writing. When you file an expedited grievance, Empire will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within 72 hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

DECISION ON GRIEVANCES

Empire's notice of its Grievance decision (whether standard or urgent) will include:

- The reason for Empire's decision, or a written statement that insufficient information was presented or available to reach a determination
- The clinical rationale, if appropriate, and
- For Level 1 Grievances, instructions on how to file a Level 2 Grievance if you are not satisfied with the decision

HOW TO FILE AN APPEAL OR GRIEVANCE

To submit an appeal or grievance, call Member Services at 1-800-342-9816, or write to the following address with the reason why you believe our decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

Empire BlueCross BlueShield
Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

If your grievance or appeal concerns behavioral healthcare, call 1-800-635-6626 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

Ending and Continuing Coverage

WHEN COVERAGE ENDS

Your Empire plan coverage may terminate for any of the following reasons:

- Your group terminates the contract
- Your employer no longer meets our underwriting standards
- Your employer fails to pay premiums
- You fail to pay premiums (if required)
- The covered employee dies
- You or your covered dependents no longer meet your employer's or the contract's eligibility requirements
- You or your covered dependents have made a false statement on an application for coverage or on a health insurance claim form, or you or your group have otherwise engaged in fraud
- Empire discontinues this class of coverage

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. To be eligible, a qualified beneficiary must be enrolled in the plan on the day before the qualifying event. A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of the federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Plan Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including*:* open enrollment and special enrollment rights.

Notice of Qualifying Events:

Your plan will offer COBRA continuation coverage (generally, the same coverage that the qualified beneficiary had immediately before qualifying for coverage) to qualified beneficiaries only after your Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, if your plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to your employer, or you becoming entitled to Medicare benefits (under Part A, Part B, or both, if applicable), your employer must notify your Plan Administrator of the qualifying event.

For the other qualifying events, (your divorce or legal separation, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Group Benefit Administrator.

HOW LONG WILL CONTINUATION COVERAGE LAST?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Group Benefit Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your plan administrator for additional information. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

To elect continuation coverage, you must complete the Cobra Continuation Coverage Election Form available from your Plan Administrator and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified

beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. Contact your Plan Administrator for additional information.

[*For employees eligible for trade adjustment assistance:* The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

WHEN AND HOW MUST PAYMENT FOR COBRA CONTINUATION COVERAGE BE MADE?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact your Plan Administrator or other party responsible for COBRA administration under the Plan to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the Election Notice. If you fail to make a periodic payment before the end of any applicable grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

FOR MORE INFORMATION

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Group Benefit Administrator at your employer.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

THE RIGHT TO ELECT ADDITIONAL CONTINUED COVERAGE UNDER NEW YORK STATE LAW WHEN CONTINUED COVERAGE UNDER FEDERAL LAW ENDS

Covered Persons who have exhausted continued coverage available under COBRA may purchase additional continued coverage as permitted by the New York State Insurance Law up to a total of thirty-six (36) months from the date continued coverage under federal COBRA began.

Note: This right to elect additional continued coverage does not apply to Covered Members who elect to continue coverage through age twenty-nine (29) under the New York Young Adult Mandatory Right of Election.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

If you are not entitled to continuation of coverage under COBRA (for example, your employer has fewer than 20 employees), you may be entitled to continue coverage under New York State Law. These laws vary from those under COBRA, but generally also require continued coverage for up to 18, 29 or 36 months.

Call or write to your employer or Empire to find out if you are entitled to continuation of coverage under the New York State Insurance Law.

THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

The Veterans Benefits Improvement Act of 2004, which amends the 1994 Uniformed Services Employment and Reemployment Rights Act (USERRA), extends the period for continuation of health care coverage as follows:

If a covered person's health plan coverage would terminate because of an absence due to military service, the person may elect to continue the health plan coverage for up to 24 months after the absence begins or for the period of service. Similar to COBRA, the person cannot be required to pay more than 102 percent (except where State requirements provide for a lesser amount) of the full premium for the coverage. If military service was for 30 or fewer days, the person cannot be required to pay more than the normal employee share of any premium.

RESERVISTS SUPPLEMENTARY CONTINUATION AND CONVERSION

If the group's plan qualifies as an employer group heath plan subject to federal continuation of coverage provision of COBRA, previously described, the supplementary continuation and conversion right described in this section does not apply.

- If a covered member who is a member of a reserve component of the armed forces of the United States, including the National Guard, enters upon active duty and the group does not voluntarily maintain coverage for such member, coverage will be suspended unless the member elects in writing, within 60 days of being ordered to active duty, to continue coverage under this program for the covered member and their eligible covered dependents. Such continued coverage shall not be subject to evidence of insurability. The member must pay the group the required group rate premium in advance, but not more frequently than once a month.
- Reservists' supplementary continuation will not be available to any person who is, could be, covered by Medicare or any other group coverage. Coverage available to active duty members of the armed forces will not be considered group coverage for the above purposes.
- In the event that the Member is re-employed or restored to participation in the Group upon return to civilian status after the period of continuation of coverage or suspension, the member will be entitled to resume coverage under program for the member and eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion or waiting period will be imposed in connection with resumed coverage except regarding:
  - a condition that arose during the period of active duty and that has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or
  - a waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

In the event that the covered member is not re-employed or restored to participation in the group upon return to civilian status, the member shall have the right within 31 days of the termination of active duty, or discharge from hospitalization, incident to active duty which continues for a period of not more than one (1) year, to submit a written request for continuation to the group, or a request for conversion directly to Empire, as described in this booklet. Such individual conversion policy will be effective on the day after the end of the period of supplementary continuation. If the member elects supplementary continuation or if coverage is suspended, the supplementary conversion right will be available to the member's spouse if divorce or annulment of the marriage occurs during the period of active duty, and, in the event the member dies while on active duty, to the member's spouse and children, and to each individually upon attaining the limiting age of coverage under this program, but not the child's dependents.

CONVERTING YOUR COVERAGE

Under certain circumstances, you can convert your group coverage to individual coverage with comparable benefits. Or you can convert your group coverage to a Medicare supplement policy, if appropriate. However, not all your current benefits may be available when you convert your coverage.

You may convert your group coverage under any of these circumstances:

- You, your spouse or dependent child no longer qualifies as a family member under the contract because:
- Your child no longer qualifies as a covered dependent
- Your covered incapacitated child no longer qualifies as incapacitated
- Your spouse divorces or annuls your marriage
- You die
- You no longer qualify as a group member
- Your company no longer meets our underwriting standards
- Your company terminates the contract and does not offer replacement coverage to group members
- You are a member or the spouse of a member and have elected Medicare as your primary coverage

You must advise your company before you or a covered dependent are no longer eligible for coverage, so Empire can continue coverage under a conversion contract. If more than 63 calendar days elapse between your old and new coverage, you will have to satisfy a new waiting period.

To convert your coverage, you must:

- Be a New York State resident within Empire's operating area,
- Apply within 90 calendar days of the date your group contract terminates (application timeframes may vary; please refer to your contract or see your Benefits Administrator), and
- Pay the premiums for the conversion contract when due.

To request an application or obtain additional information on converting your coverage, call 1-800-261-5962.

If you are converting to a Medicare Supplement policy, and you live outside New York State, you should contact your local Blue Cross or Blue Shield plan.

You may not convert your group coverage, if coverage ends because:

- You fraudulently filed the Notice of Election
- You were never a legitimate group member
- The group replaced this contract with similar continuous coverage from another insurance carrier
- You filed false or improper claims, or for any other similar reasons approved by the Insurance Department

ENDING AND CONTINUING COVERAGE

Your Employer/Plan Sponsor reserves the right to amend or terminate its group health plan coverage provided to you at any time without prior notice or approval. The decision to end or amend the health plan coverage may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason.

Any amendment or termination may apply to all or any portion of the group health plan coverage and to all or to only a portion of the participants and beneficiaries.

PORTABILITY OF COVERAGE

Your contract may require an 11-month waiting period before paying benefits for pre-existing conditions for members age 19 and older.. At the same time you may be eligible for credit toward the satisfaction of this waiting period. If you had similar coverage (hospital, medical or major medical) from another insurance carrier before the effective date of your Empire coverage, you will receive credit for whatever waiting period you met under the prior contract (Creditable Coverage). The pre-existing condition provision in your Empire contract provides that credit towards the pre-existing condition waiting period will be given for the time you were previously covered under Creditable Coverage of a prior plan, if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the enrollment date under your Empire plan.

Please note that you have a right to request a certificate of Creditable Coverage from a prior plan or issuer, free of charge, and that Empire will assist you in obtaining a certificate from any prior plan or issuer, if necessary.

To determine whether you are eligible for portability of coverage, you must provide Empire with the certificate of Creditable Coverage or a letter of proof from the prior carrier or group that contains the covered person's name, contract type, start and end dates of coverage, and names of covered dependents. The evidence of prior coverage should be submitted immediately to avoid possible claim rejections.

IF YOU BECOME DISABLED

If you or your covered dependents are totally disabled when coverage ends, coverage will continue for the disabled person for expenses related to the injury or illness that caused the disability. These benefits may continue for a period of 12 months following the date coverage ended.

Coverage will end when the disabled person:

- Is no longer totally disabled
- Has received maximum benefits from the contract
- Becomes eligible for total disability under another group program

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

If you and/or your covered dependents become eligible for Medicare, you can continue your health benefits under the plan.

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Deficit Reduction Act of 1984 (DEFRA), if you or your spouse is over age 65, you or your spouse can designate this program, rather than Medicare, as primary coverage if the following conditions apply:

- Your group employs 20 or more people
- You are an active employee or spouse of an active employee, and
- Your group notifies us that you or your spouse chooses the group's coverage as primary, and pays the appropriate premium

Under the Omnibus Budget Reconciliation Act of 1986 (OBRA), if you, your spouse or your dependent child or your dependent(s) are eligible for Medicare due to disability, you, your spouse or dependent child can designate this program as your primary coverage if:

- Your group employs 100 or more people
- You are an active employee, and
- Your group notifies us that you or your covered dependents become entitled to Medicare disability, and they pay the appropriate premium. If you designate Medicare as primary, your coverage under this group plan ends.

CARVE-OUT PROGRAM

If the above conditions do not apply, and the covered person is Medicare eligible, he/she will receive this program's benefits reduced by Medicare's benefits ("carve-out") This limitation applies even if you or your spouse fail to enroll in Medicare or do not claim the benefits available under Medicare.

Carve-out is a program for some subscribers who are eligible for Medicare and for whom Medicare is primary. You will receive the same benefits as the non-Medicare members in your group less the amount paid by Medicare. You or your healthcare provider should file a claim with Medicare, not Empire. After Medicare processes your claim, forward the Medicare EOB to Empire for additional processing.

As a carve-out subscriber, you must meet the same contractual requirements (e.g., coinsurance, maximum allowances, etc.) as non-Medicare eligible employees. You must also meet the Medicare Part B deductible.

Carve-out benefits are not available for a service that is not covered by your group's plan.

Your ERISA Rights

Empire feels it is important for every member to know his/her rights, so please review the following information.

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections under ERISA. Under ERISA you are entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report filed by the plan with the U.S. Department of Labor or Internal Revenue Service.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each covered member with a copy of this summary annual report.

Duties of the Plan Fiduciaries

In addition to creating certain rights for covered members, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate the plan, called plan "fiduciaries," have a duty to do so prudently and in the interest of you and other covered members. Your employment cannot be terminated, nor can you be discriminated against in any way, to prevent you from obtaining your benefits or exercising your rights under ERISA.

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a covered member of the plan.

- Under ERISA, you have the right to have your Plan Administrator review and reconsider your claim. If we deny a claim, wholly or partly, you may appeal our decision. You will be given written notice of why the claim was denied, and of your right to appeal the decision. You have 180 days to appeal our decision. You, or your authorized representative, may submit a written request for review. You have the right to obtain copies of documents relating to the decision without charge. You may ask for a review of pertinent documents, and you may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision. If your claim for benefits is ignored or denied, in whole or in part, you may file suit in a state or federal court. A lawsuit for benefits denied under this coverage can be filed no earlier than 60 days after the claim was filed, and no later than two years from the date that the services were received. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If you submit a written request for copies of any plan documents or other plan information to which you are entitled under ERISA and you do not receive them within 30 days, you may bring a civil action in a federal court. The court may require the Plan Administrator to pay up to $110 for each day's delay until you receive the materials. This provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.
- In the unlikely event that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. But if you lose, because, for example, the case is considered frivolous, you may have to pay all costs and fees.

If you have any questions about your plan, contact your Plan Administrator or Member Services at 1-800-342-9816.

If you have any questions about your rights under ERISA, contact the regional office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor.

U.S. Department of Labor
Employee Benefits Security Administration (EBSA)
Director, New York Regional Office
33 Whitehall Street
New York, NY 10004
Telephone: 1-212-607-8600
Fax: 1-212-607-8681
Toll-Free: 1-866-444-3272

Confidentiality Policy

In recognition of the need for member privacy, and in compliance with federal and state laws and regulations, Empire has a policy on the confidentiality of member medical information.

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information, which is used, disclosed, exchanged or transmitted orally, in writing or electronically.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and federal and state laws and regulation concerning the request for use, disclosure, transmission, release, security, storage and destruction of confidential member medical information.
- Empire does not disclose our members' nonpublic personal information to any of our affiliates or to nonaffiliated third parties, except as permitted by law to allow us to conduct our business.
- Disclosure of confidential information to external vendors for purposes of payment or health care operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.
- Identifiable personal health information is not shared with your employer, unless permitted or required by law.
- Because Empire is not a provider of medical services, it generally does not maintain medical records created by your provider of service. If you require access to your provider's medical records, please contact your provider to arrange access.
- Empire contractually requires all of its network practitioners and providers to ensure the privacy and to protect the confidentiality of members' medical information.
- When you become covered under your Empire health benefit plan, you agree that Empire, or its designee, may use and/or disclose your confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Empire member agrees that any healthcare provider, healthcare payor or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made for use and/or disclosure by Empire to administer the terms of the health benefit plan.
- You may request access to any other information that is maintained by or for Empire by calling Member Services to arrange access. You may request an amendment of records maintained by and for Empire, or you may request an accounting of disclosures as permitted by law.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release, authorized by the member or member's designee, which may be revoked at any time. The authorization must be signed and dated and must specify:
  - The information that can be disclosed and to whom
  - What the information will be used for, and
  - The time period for which the authorization applies.

For additional information regarding the confidentiality of member medical information, please read Empire's Notice of Privacy Practices. Go to www.empireblue.com and click on "Privacy Notices" at the bottom of the homepage. If you would like a printed copy of this policy please call Empire Member Services at the toll-free number on your identification card. Please refer to the Notice of Privacy Practices section for more information.

ACCESS TO INFORMATION

In addition to calling Member Services for claim and benefit information, you can contact them for:

- The names, business addresses and official positions of Empire's Board of Directors, officers, controlling persons, owners and partners
- Empire's most recently published annual financial statement
- A consumer report of grievances filed with the Insurance Superintendent
- Procedures that protect confidentiality of medical records and information
- A copy of Empire's Drug Formulary
- A directory of participating providers
- A description of our quality assurance program
- A notice of specific individual provider affiliations with participating hospitals
- Upon written request, specific written clinical criteria for determining if a procedure or test is medically necessary

For Members Who Don't Speak English

Empire will help members who speak languages other than English ask questions and file grievances in their first language. When you call Member Services, the operator will link you to an interpreter in your preferred language, who can facilitate the discussion. 24/7 NurseLine is also equipped to provide assistance in most languages.

HIPAA Notice of Privacy Practices

Effective July 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We
may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.

- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.

- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA Privacy Requirements

EMPLOYER/SPONSOR

1. Under the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations (45 C.F.R. Parts 160 and 164), referred to as HIPAA, the Employer/Sponsor of a Group Health Plan (the "Plan") may obtain and use a member's summary information[1] for purposes of obtaining premium bids, to modify, amend or terminate the Plan, and for enrollment and eligibility determinations.

Under the requirements of HIPAA, the Employer/Sponsor may obtain and use a member's Protected Health Information, including electronic protected health information (PHI)[2], for purposes of Plan Administration. To the extent the Employer/Sponsor requires PHI, and prior to receiving PHI, the Employer/Sponsor shall certify to the Plan that the Plan Documents meet the requirements of HIPAA (as described below).

EMPLOYER/SPONSOR OBLIGATIONS

2. The Employer/Sponsor agrees to comply with the following in order to obtain PHI about members for the permissible limited uses or disclosures for the Plan administration functions it performs.

Purpose of Disclosure to Employer/Sponsor

(a) The Plan and any health insurer or HMO will disclose members' PHI to the Employer/Sponsor only to permit the Employer/Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer/Sponsor of members' PHI will be subject to and consistent with the provisions of this section.

(b) Neither the Plan nor any health insurance issuer or HMO will disclose members' PHI to the Employer/Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the members.

(c) Neither the Plan nor any health insurance issuer or HMO will disclose members' PHI to the Employer/Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

3. (a) The Employer/Sponsor will neither use nor further disclose members' PHI, except as permitted or required by the Plan Documents, as amended or required by law.

(b) The Employer/Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI.

(c) The Employer/Sponsor will ensure that any agent, including any subcontractor, to whom it provides members' PHI, agrees to these restrictions and conditions, including implementing reasonable and appropriate security measures in the Plan Documents, with respect to members' PHI.

(d) The Employer/Sponsor will not use or disclose members' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit Plan of the Employer/Sponsor.

(e) The Employer/Sponsor will report to the Plan any use or disclosure or security incident of members' PHI that is inconsistent with the allowed uses and disclosures promptly upon learning of such inconsistent use or disclosure.

(f) The Employer/Sponsor will make PHI available to the member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524, Access of Individual to PHI.

(g) The Employer/Sponsor will make members' PHI available for amendment, and will on notice amend members' PHI, in accordance with 45 Code of Federal Regulations § 164.526, Amendment of PHI.

(h) The Employer/Sponsor will track disclosures it may make of members' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528, Accounting of Disclosures of PHI.

(i) The Employer/Sponsor will make its internal practices, books, and records, relating to its use and disclosure of members' PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

(j) The Employer/Sponsor will, if feasible, return or destroy all member PHI, in whatever form or medium (including in any electronic medium under the Employer's/ Sponsor's custody or control), received from the Plan that the Employer/Sponsor still maintains, including all copies of and any data or compilations derived from and allowing

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[1] *Summary information summarizes the claims history, claims expenses, or types of claims of individuals covered under a group health plan, and from which individual identifiers have been removed.*

[2] *Health information that is received, created, maintained or transmitted in electronic form or in any other form or medium by a health plan, insurer or HMO that identifies the individual or can be used to identify the individual and that relates to an individual's physical or mental health or condition, including information related to an individual's care or the payment for such care.*

identification of any Participant who is the subject of the PHI, when the members' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all members' PHI, the Employer/Sponsor will limit the use or disclosure of any member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation between the Employer/Sponsor and the Plan

4. (a) The Employer/Sponsor will ensure the adequate separation between employees and the Plan, supported by reasonable and appropriate security measures.

1) All employees or classes of employees or other workforce members under the control of the Employer/Sponsor may be given access to or may receive members' PHI relating to payment under or health care operations of the Plan, or other matters pertaining to the Plan in the ordinary course of business.

2) The employees, classes of employees or other workforce members identified above will have access to members' PHI only to perform the Plan administration functions that the Employer/Sponsor provides for the Plan.

(b) The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer/Sponsor, for any use or disclosure or security incident of members' PHI in breach or violation of or noncompliance with these provisions of the Plan Documents. The Employer/Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(e), and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy or security of whose PHI may have been compromised by the breach, violation or noncompliance.

Definitions

Refer to these definitions to help you better understand your coverage. Need more help? Additional terms and definitions can be viewed at *www.empireblue.com*.

Adverse Determination

A communication from Empire's Medical Management that reduces or denies benefits.

Allowed Amount

The maximum Empire will pay for a covered service out-of-network. The allowed amount is based on an agreement between Empire and the provider, or if there is no agreement, then on the customary charge or the average market charge in your geographic area for a similar service. You are responsible for paying the entire portion above the allowed amount

Ambulatory Surgery

See "same-day surgery."

Annual Out-of-Pocket Coinsurance Maximum

The most you will have to pay in out-of-pocket costs for coinsurance on covered services received during a calendar year. When you meet the out-of-pocket coinsurance maximum, the plan pays 100% of the allowed amount for covered expenses for the remainder of that calendar year. Your co-payment s, deductible, the coinsurance for behavioral healthcare expenses, and any amount you pay above the out-of-network allowed amount do not count toward your annual out-of-pocket coinsurance maximum.

Authorized Services

See "precertified services."

BlueCard® Program

The BlueCard Program helps reduce your costs when you obtain out-of-network care outside of the geographic area served by Empire from a provider who participates with another Blue Cross and/or Blue Shield Plan ("local Blue Plan"). Just show your Empire ID card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services.

When you obtain healthcare through the BlueCard Program, the portion of your claim that you are responsible for ("member liability") is, in most instances, based on the **lower** of the following:

- the billed amount that the participating provider actually charges for covered services, or
- the negotiated price that the local Blue Plan passes on to Empire.

Here's an example of a negotiated price and how it benefits you:

A provider's standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, you pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

- a simple discount from the provider's usual charges, which is the amount that would be reimbursed by the local Blue Plan;
- an estimated price that has been adjusted to reflect expected settlements, withholds, any other contingent payment arrangements and any non-claim transactions with the provider; or
- the provider's billed charges adjusted to reflect average expected savings that the local Blue Plan passes on to Empire. If the negotiated price reflects average savings, it may vary (more or less) from the actual price than it would if it reflected the estimated price.

Plans using the estimated price or average savings methods may adjust their prices in the future to ensure appropriate pricing. However, the amount you pay is considered the final price.

A small number of states have laws that require that your member liability be calculated based on a method that does not reflect all savings realized, or expected to be realized, by the local Blue Plan on your claim, or that requires that a surcharge be added to your member liability. If you receive covered healthcare services in any of these states, member liability will be calculated using the state's statutory methods that are in effect at the time you receive care.

If you have any questions about the BlueCard Program, contact Member Services.

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of physicians, hospitals and other healthcare providers. As a PPO member, you have access to these networks through the BlueCard PPO Program to receive in-network benefits for covered services. By presenting your Empire I.D. card to a provider participating in the BlueCard PPO Program, you receive the same benefits as you would receive from an Empire PPO network provider. The suitcase logo on your I.D. card indicates that you are a member of the BlueCard PPO Program. Call 1-800-810-BLUE (2583) or visit *www.bcbs.com* to locate participating providers.

BlueCard® Worldwide Program

The BlueCard Worldwide program provides hospital and professional coverage through an international network of healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance. Here's how to use BlueCard Worldwide:

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®1 Access Number.

Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any co-payment and amount above the allowed amount.

Coinsurance

When you get care out-of-network, you and your PPO share the cost of covered expenses, after you meet the deductible. For example, if your PPO pays 70% of the allowed amount, you pay 30% plus any costs above the allowed amount. Once your coinsurance expenses reach the annual out-of-pocket maximum, your PPO will pay 100% of the provider's charge or the allowed amount, whichever is less.

Co-payment

The fee you pay for office visits and certain covered services when you use in-network providers. The plan then pays 100% of remaining covered expenses.

Covered Services

The services for which Empire provides benefits under the terms of your contract. For example, Empire covers one in-network annual physical exam.

Deductible

The dollar amount you must pay each calendar year before your plan pays benefits for covered out-of-network services. If you have family coverage, once the first family member meets the individual deductible, the plan will pay benefits for that family member. However, the benefits for other family members will not be paid until two or more eligible family members meet the family deductible. Once the family deductible is met, your PPO plan will pay benefits for covered out-of-network services for the remainder of the year for all eligible family members. The exception to this rule is a common accident benefit – if two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

Hospital/Facility

For purposes of certifying inpatient services, a hospital or facility must be a fully licensed acute-care general facility that has all of the following on its own premises:

- A broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- A fully-staffed operating room suitable for major surgery, together with anesthesia service and equipment. The hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care
- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan.

For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or another Blue Cross and/or Blue Shield plan other than specified above.

For kidney dialysis treatment, a facility in New York State qualifies for in-network benefits if the facility has an operating certificate issued by the New York State Department of Health, and participates with Empire or another Blue Cross and/or Blue Shield plan. In other states, the facility must participate with another Blue Cross and/or Blue Shield plan and be certified by the state using criteria similar to New York's. Out-of-network benefits will be paid only for non-participating facilities that have an appropriate operating certificate.

For behavioral healthcare purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

For certain specified benefits, the definition of a "hospital" or "facility" may include a hospital, hospital department or facility that has a special agreement with Empire.

Empire does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps.

In-Network Benefits

Benefits for covered services delivered by in-network providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Itemized Bill

A bill from a provider, hospital or ambulance service that gives information that Empire needs to settle your claim. Provider and hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. A provider bill will also have the provider's name and address and descriptions of each service, while a hospital bill will have the subscriber's name and address, the patient's date of birth and the plan holder's Empire identification number. Ambulance bills will include the patient's full name and address, date and reason for service, total mileage traveled, and charges.

Lifetime Maximum

The maximum amount of benefits your plan will pay for covered expenses over the course of your lifetime.

Medically Necessary

Services, supplies or equipment provided by a hospital or other provider of health services that are:

- Consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury,
- In accordance with standards of good medical practice,
- Not solely for the convenience of the patient, the family or the provider,
- Not primarily custodial, and
- The most appropriate level of service that can be safely provided to the patient.

The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's PPO contract. Or, a hospital or facility that does not accept negotiated rate arrangements as payment in full in a plan area without a PPO network.

Operating Area

Empire operates in the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester.

Out-of-Network Benefits

Reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs.

Out-of-Network Providers/Suppliers

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who:

- Is not in Empire's PPO network
- Is not in the PPO network of another Blue Cross and/or Blue Shield plan
- Does not have a negotiated rate with another Blue Cross and/or Blue Shield plan

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that:

- Is in Empire's PPO network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Plan Administrator

The person who has certain authority concerning the health plans, such as plan management, including deciding questions of eligibility for participation, and/or the administration of plan assets. Empire is not the Plan Administrator. To identify your Plan Administrator, contact your employer or health plan sponsor.

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by your plan. For example, planned inpatient surgery, MRIs and MRAs. Failure to precertify may result in a reduction or denial of benefits.

Provider

A hospital or facility (as defined earlier in this section), or other appropriately licensed or certified professional healthcare practitioner. Empire will pay benefits only for covered services within the scope of the practitioner's license.

For behavioral healthcare purposes, "provider" includes care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.

For maternity care purposes, "provider" includes a certified nurse-midwife affiliated with or practicing in conjunction with a licensed facility and whose services are provided under qualified medical direction.

Same-Day Surgery

Same-day, ambulatory or outpatient surgery is surgery that does not require an overnight stay in a hospital.

Treatment Maximums

Maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined. For example, if the plan has a limit of 30 visits on a covered expense, you would reach the limit if you had 17 visits in-network and 13 visits out-of-network.

EMPIRE HEALTHCHOICE ASSURANCE, INC.
(the "Company")
RIDER TO YOUR
CONTRACT OR CERTIFICATE
RE: ENROLLING A NEWBORN CHILD

This rider amends the requirements for enrolling a newborn child under your Contract, Certificate, or Group Plan as described below:

A. For a Member who has individual (for self only), employee\spouse, or parent\child (two person) coverage:
   1. He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
   2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
   3. If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form, provided that it is during the next open enrollment period after the birth or within the first year after the birth, which ever occurs first.
   4. If you do not switch to a parent\child, parent\children, or family contract and enroll your newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Contract, Certificate or Group Plan.

B. For a Member who has family or parent\children (more than two person) coverage:
   1. A newborn child, or a proposed adopted newborn, will be covered from the date of birth.
   2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.
   3. Coverage will still be effective from the date of birth for a newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
   4. Any claims for a newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled.

C. All of the terms, conditions, and limitations of the Contract, Certificate, or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.

Nancy L. Purcell
Corporate Secretary

Mark Wagar
President

R-Newborn Enrollment (EHCA)

LGL 10037E (9/07)

AudioHealth Library Topics

Following is a list of some of our most popular health-related audiotape topics that you can listen to free of charge, 24 hours a day, seven days a week, when you call 24/7 NurseLine at 1-877-TALK-2RN (825-5276). See the 360˚ Health section for more information on the 24/7 NurseLine and instructions on how to listen to the tapes. These are our most requested audiotapes. If you do not see the topic that interests you, just ask one of the NurseLine nurses.

Abdominal Problems

1600 Appendicitis
1451 Constipation
1618 Crohn's Disease
1260 Dehydration
1452 Diarrhea
1605 Diverticulosis and Diverticulitis
1402 Food Poisoning
1608 Gallbladder Disease
2154 Gallbladder Surgery
1612 Gastroesophageal Reflux Disease
1610 Heartburn
1952 Hepatitis
1403 Hernia
1603 Inflammatory Bowel Disease
1611 Irritable Bowel Syndrome
2576 Kidney Stones
1462 Nausea and Vomiting
1609 Rectal Problems
1613 Ulcers
2257 Urinary Incontinence in Women
1291 Urinary Tract Infections

Allergies

1000 Allergies
2770 Drug Allergies
1002 Food Allergies
1007 What About Allergy Shots?

Back and Neck Pain

1450 Low Back Pain
1463 Herniated Disk
2174 Low Back Problems , Surgery for
1457 Neck Pain

Bone, Muscle and Joint Problems

1030 Arthritis
1780 Bunions
2103 Bursitis and Tendon Injury
1781 Calluses and Corns
2104 Carpal Tunnel Syndrome
1038 Fibromyalgia
1039 Gout
1784 Heel Spurs
1031 Juvenile Rheumatoid Arthritis
1033 Lupus
2106 Muscle Cramps and Leg Pain
2259 Osteoarthritis
1032 Osteoporosis
1034 Rheumatoid Arthritis
2169 Rotator Cuff
1456 Sports Injuries
2105 Strains, Sprains, Fractures and Dislocations
2151 Surgery for Carpal Tunnel Syndrome
1461 TM Disorder

Cancer

1105 Cancer Pain
1110 Colon Polyps
1113 Colorectal Cancer
1120 Women's Cancer
1124 Lung Cancer

Chest, Respiratory and Circulatory Problems

1981 Asthma in Teens and Adults
1908 Atrial Fibrillation (irregular heartbeats)
1983 Bronchitis
1915 Cardiac Rehabilitation
1903 Causes of Heart Attack
1900 Chest Pain
1976 Chronic Obstructive Pulmonary Disease (COPD)
1400 Colds
1907 Heart Failure
1980 Emphysema
1455 Fever
1904 Heart Attack Prevention
1401 Influenza (Flu)
1648 Laryngitis
1910 Mitral Valve Prolapse
1911 Pacemakers
1986 Pneumonia
1406 Sinusitis
1459 Sore Throat and Strep Throat
1081 Stroke Rehabilitation
1460 Swollen Lymph Nodes
1912 Varicose Veins
1407 Viral and Bacterial Infection

Chronic Conditions

1060 ALS (Lou Gehrig's Disease)
1061 Alzheimer's Disease
1950 Chronic Fatigue Syndrome
2570 Chronic Kidney Disease
1063 Epilepsy
1953 Hepatitis B
1909 High Blood Pressure
1832 High Cholesterol
2623 Iron Deficiency Anemia
1959 Living with HIV Infection
1065 Multiple Sclerosis
1066 Parkinson's Disease
1512 Prediabetes
2550 Thyroid Problems
1508 Type 1 Diabetes
1500 Type 2 Diabetes
1501 Type 2 Diabetes: Living with Complications
1502 Type 2 Diabetes: Living with the Disease
1503 Type 2 Diabetes: Recently Diagnosed

Ear, Nose and Throat

1516 Diabetic Retinopathy
1453 Dizziness and Vertigo
1264 Ear Infections
1640 Earwax
1646 Hearing Loss
1641 Inner Ear Infection (Labrynthitis)
1644 Meniere's Disease
1643 Swimmer's Ear
1650 Tonsillitis

Eye Problems

1700 Eye Problems
2152 Cataract Surgery
1709 Cataracts
1710 Color Blindness
1703 Contact Lens Care
1708 Eye Infections
1705 Eye Injuries
1717 Floaters and Flashes
1712 Glaucoma
1711 Macular Degeneration
1716 Laser Surgery for Nearsightedness
1713 Strabismus
1707 Styes
1702 Vision Tests

First Aid and Emergencies

1750 Animal and Human Bites
1761 Burns
1255 Choking
1762 Cuts
2337 Frostbite
1901 Heart Attack
1759 Heat Exhaustion and Heat Stroke
2256 Hypothermia
2203 Importance of CPR Instructions
1751 Insect and Spider Bites and Stings
1458 Nosebleeds
1763 Poisoning
1764 Puncture Wounds
1766 Removing Splinters
1752 Snake Bites
1067 Stroke
1754 Tick Bites

Headaches and Nervous System Problems

1062 Bell's Palsy
1515 Diabetic Neuropathy
1068 Guillain-Barre Syndrome
1064 Encephalitis
1405 Migraine Headaches
1404 Tension Headaches

Home Health Medicines and Supplies

2000 Bulking Agents and Laxatives
2007 Cold and Allergy Remedies
2003 Cough Preparations
2002 Decongestants
1270 How to Take a Temperature
2001 Pain Relievers
1758 Self-Care Supplies

Infant and Child Health

1250 ADHD
1251 Bed-wetting
2753 Bottle-feeding
1254 Chickenpox
1278 Childhood Rashes
1256 Circumcision
1257 Colic
1258 Croup
1261 Diaper Rash

Infant and Child Health

1080 Dyslexia
2436 Fetal Alcohol Syndrome
1253 Fever, Age 3 and Younger
1267 Fifth Disease
1268 Growth and Development of the Newborn
1269 Hand-Foot-Mouth Disease
1837 Healthy Eating for Children
1272 Impetigo
1274 Measles
1275 Mumps
1280 Pinworms
1259 Reye's Syndrome
1283 Roseola
1284 Rubella (German Measles)
1287 Sudden Infant Death Syndrome (SIDS)
1288 Teething
1247 Temper Tantrums
1292 Thrush
1289 Thumb-Sucking
1290 Toilet Training
1293 Urinary Tract Infections in Children

Infectious Diseases

1408 Avian Influenza (Bird Flu)
1951 Infectious Mononucleosis
1956 Tuberculosis
1965 West Nile Virus

Living Healthy

1279 Immunizations
1295 Health Screenings
1830 Living a Balanced Lifestyle
1831 Guidelines for Eating Well
1833 Be Physically Active
1834 Healthy Weight
1835 Mind-Body Connection
1838 Alcohol and Drug Problems
1841 Be Tobacco-Free
1846 Managing Stress
1853 Healthy Snacks
1964 Relaxation Skills
2204 Accident and Injury Prevention
2428 Treatment for Alcohol Use Problems
2435 Teen Alcohol and Drug Abuse

Medical Tests and Procedures

1506 Home Blood Sugar Monitoring
1532 Exercise Electrocardiography
1533 Complete Blood Count (CBC)
1534 Chest X-ray
1535 Chorionic Villus Sampling
1536 CT Scan of the Body
1537 Electroencephalogram
1538 Electrocardiogram
1539 Electromyography (EMG)
1540 Barium Enema
1541 Upper Gastrointestinal (GI) Series
1542 Magnetic Resonance Imaging
1546 Lung Function Tests
1547 Abdominal Ultrasound
2155 Cystoscopy
2156 Dilation and Curettage
2157 Episiotomy
2158 Surgery for Hemorrhoids
2159 Hernia Surgery
2160 Hip Replacement Surgery
2162 Arthroscopy
2163 Knee Replacement Surgery
2164 Laparoscopy
2165 Ear Tubes
2171 Tonsillectomy and Adenoidectomy
2503 Shared Decisions about Surgery

Men's Health

1128 Prostate Cancer
1545 Prostate-Specific Antigen Test (PSA Test)
2031 Hair Loss
2034 Benign Prostatic Hyperplasia (Enlarged Prostate)
2036 Testicular Problems
2167 TURP for BPH

Mental Health Problems and Mind-Body Wellness

1069 Bipolar Disorder
1070 Schizophrenia
1071 Dementia
1230 Domestic Violence
1240 Child Maltreatment
1845 Stress Management
2051 Obsessive-compulsive Disorder
2052 Eating Disorders
2055 Panic Attacks and Panic Disorder
2057 Depression
2059 Grief
2063 Social Anxiety Disorder
2066 Suicide

Partnership with your doctor

1201 Patients Bill of Rights
1202 Caregiver Secrets
1800 Skills for Making Wise Health Decisions
1801 Work in Partnership with your Doctor
1802 Finding a Doctor Who Will be a Partner

Senior Health

1836 Seniors Staying Active and Fit
2004 Medication Problems in Seniors
2006 Medications and Older Adults
2240 Hospice Care
2245 Care at the End of Life
2251 Nutrition for Older Adults
2261 Skin and Nail Problems in Seniors

Skin Problems

1129 Skin Cancer
1273 Lice and Scabies
1755 Blisters
1785 Ingrown Toenails
2330 Acne
2332 Boils
2333 Cold Sores
2334 Dandruff
2336 Atopic Dermatitis
2338 Hives
2343 Rashes
2344 Psoriasis
2346 Fungal Infections
2349 Shingles
2352 Sunburn
2353 Warts

Sleeping Disorders

2400 Sleep Problems
2403 Sleep Apnea
2406 Snoring

Women's Health

1107 Breast Health
1111 Ovarian Cancer
1112 Polycystic Ovary Syndrome
1211 Multiple Pregnancy: Twins or More
1504 Gestational Diabetes
1531 Breast Biopsy
1544 Pelvic Exam and Pap Test
1548 Ultrasound for Normal Pregnancy
2312 Pelvic Inflammatory Disease
2426 Pregnancy, Precautions During
2640 Bacterial Vaginosis
2643 Yeast Infections
2650 Menopause
2651 Hormone Therapy
2670 Missed or Irregular Periods
2672 Endometriosis
2673 Uterine Fibroids
2674 Hysterectomy
2675 Bleeding Between Periods
2677 Functional Ovarian Cysts
2678 Menstrual Cramps
2679 Dsyfuntional Uterine Bleeding
2680 Toxic Shock Syndrome
2700 How to Make a Healthy Baby
2701 Home Pregnancy Test
2704 Danger signs during pregnancy
2705 Normal Pregnancy
2706 Symptoms and Stages of Labor
2708 Diet During Pregnancy
2709 Exercise During Pregnancy
2710 Rubella and Pregnancy
2714 Amniocentesis
2717 Miscarriage
2719 Stretch Marks
2720 Cesarean Section
2723 Pelvic Organ Prolaps
2724 Premenstrual Syndrome

Women’s Health

2725 Pregnancy, Symptoms and Stages of
2750 Postpartum Depression
2751 Breast Feeding
2752 Complications after delivery
2754 Labor, Delivery, and Postpartum Period
2755 Mastitis While Breast-Feeding
2756 Rh Sensitization During Pregnancy
2757 Weaning

*Additional topics, that are not listed, are also available.

Amendment To Member's Evidence Of Coverage

Empire HealthChoice Assurance, Inc.
11 West 42nd Street
New York, New York 10036

You are hereby notified that pursuant to Empire HealthChoice, Inc.'s conversion to a for-profit health insurer and corporate merger with Empire HealthChoice Assurance, Inc., all references in your certificate of coverage and/or benefit booklet ("evidence of coverage") to "Empire HealthChoice, Inc." are hereby changed to "Empire HealthChoice Assurance, Inc

Any claim or any right against Empire HealthChoice, Inc. you may have had under your group's contract as of the date of the conversion and merger (including, but not limited to, a right to receive payments for services incurred prior to the date of the conversion and merger) will, as a result of the conversion and merger, be against Empire HealthChoice Assurance, Inc. instead. All benefits for services received on or after the date of the conversion and merger shall be the responsibility of Empire HealthChoice Assurance, Inc.

All correspondence and inquiries concerning your coverage, including premium payments, contract changes, and notices of claims, should be submitted to:

Empire HealthChoice Assurance, Inc.
11 West 42nd Street
New York, New York 10036

Except as set forth in this Amendment, your rights as a group member will not be affected and the terms and conditions of your coverage will not be changed by reason of the conversion and merger. This Amendment forms a part of and should be attached to your evidence of coverage issued to you by Empire HealthChoice, Inc.

This Amendment hereby amends your evidence of coverage by adding the following provisions:

1. The group contract is between your group and Empire HealthChoice Assurance, Inc.

2. No statement you make will void the insurance provided by the contract or evidence of coverage, or reduce its benefits, unless it is contained in a written document you have signed. All statements contained in such a document will be deemed representations, not warranties.

3. No agent has authority to change the contract or evidence of coverage or waive any of its provisions. No change in the contract or evidence of coverage shall be valid unless approved by an officer of Empire HealthChoice Assurance, Inc. and evidenced by endorsement on the contract. A change may also be valid when it is in the form of an amendment to the contract signed by the group and Empire HealthChoice Assurance, Inc.

4. All new employees or new members in the classes eligible for insurance must be added to the class for which they are eligible

5. CONVERSION. The provisions of the group contract and your evidence of coverage that describe the conversion privilege upon termination of coverage are deleted and replaced with the following:

   If the insurance on an employee or member insured under the group contract ceases because of termination of (i) employment or of membership in the class or classes eligible for coverage under the contract or (ii) the contract, for any reason whatsoever, unless the contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group contract for at least three months shall be entitled to have issued to him by Empire without evidence of insurability upon application made to Empire within forty-five days after such termination, and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the form and amount of insurance, an individual contract of insurance. Empire may, at its option elect to provide the insurance coverage under a group insurance contract, delivered in this state, in lieu of the issuance of a converted individual contract of insurance. Such individual contract, or group contract, as the case may be, is hereafter referred to as the converted contract. The benefits provided under the converted contract shall be those required by subsection (f), (g), (h) or (i) of Section 3221 of the New York State Insurance Law, whichever is applicable and, in the event of termination of the converted group contract of insurance, each insured thereunder shall have a right of conversion to a converted individual contract of insurance.

   Written notice by your group given to you or mailed to your last known address, or written notice by Empire sent by first class mail to you at the last address furnished to Empire by your group, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

The converted contract shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group contract. If delivery of any individual converted contract is to be made outside this state, it may be on such form as Empire may then be offering for such conversion in the jurisdiction where such delivery is to be made.

Notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

6. The provisions of the group contract and your evidence of coverage that describe claim submission requirements are deleted and replaced with the following:

Written proof of claim for benefits covered under the contract must be furnished to Empire within ninety days after the date of services were rendered. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

Empire will furnish to the person making claim or to the group for delivery to such person, upon request, such forms as are usually furnished by it for filing proof of claim. If such forms are not furnished in response to such request, the person making such claim shall be deemed to have complied with the requirements of the contract as to proof of claim upon submitting within the time fixed in the contract for filing proof of claim, written proof covering the occurrence, character and extent of the services for which claim was made.

7. Benefits payable under the group contract and your evidence of coverage will be payable not more than 45 days after receipt of a claim, except in a case where our obligation to pay a claim submitted is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Insurance Department that such claim was submitted fraudulently.

8. The provisions of the group contract and your evidence of coverage that describe who will receive payment under the contract are deleted and replaced with the following:

All benefits of the group contract and your evidence of coverage are payable to the insured. Payments under the group contract and evidence of coverage for services provided by participating providers will be made directly to the participating provider.

9. Termination and Nonrenewal. The provisions of the group contract and your evidence of coverage that describe the termination and nonrenewal of the group contract are deleted and replaced with the following:

(A) The group may terminate the contract with Empire at any time upon 60 days notice. The group contract will be renewed and continued in force, except that Empire may nonrenew or discontinue coverage under the group contract based only on one or more of the following:

(1) The group has failed to pay premiums or contributions in accordance with the terms of the group contract or Empire has not received timely premium payments.

(2) The group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) The group has failed to comply with the material plan provision relating to employer contribution or group participation rules, as permitted under section four-thousand two hundred thirty-five of the Insurance Law of the State of New York.

(4) Empire ceases to offer group or blanket policies in a market in accordance with this provision.

(5) The group ceases to meet the requirements for a group under section four thousand two hundred thirty-five of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the contract is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.

(6) Where Empire offers a group contract in a market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides or works in Empire's operating area.

(7) Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of ("HIPAA") the Act.

(B) In any case where Empire decides to discontinue offering a particular class of group contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class may be discontinued only if:

(1) Empire provides written notice to the superintendent and to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety (90) days prior to the date of discontinuance of such coverage; and

(2) Empire offers to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage currently being offered by Empire to a group in such market; and

(3) Empire acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.

(C) In any case in which Empire elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued only if:

(1) Empire provides written notice to the superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

(2) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and

(3) Empire provides the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

10. Any references in the group contract and your evidence of coverage which describe Empire's right to modify the group contract or your evidence of coverage are deleted and replaced with the following:

At the time of coverage renewal only, Empire may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law, and effective on a uniform basis among all small group contract holders with the contract form.

11. All terms, conditions, limitations, and exclusions of the group contract and evidence of coverage apply to this Amendment except where specifically changed herein. If there are any inconsistencies between this Amendment and the group contract and evidence of coverage, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Empire HealthChoice, Inc. and Empire HealthChoice Assurance, Inc. have caused this Amendment to Member's Evidence of Coverage to be duly signed and issued

Michael A. Stocker, M.D.
Chief Executive Officer,
Empire HealthChoice, Inc

Michael A. Stocker, M.D.
Chief Executive Officer,
Empire HealthChoice Assurance, Inc.