Empire Hospital PPO Plan for Local 802 Musicians Health Fund Group 370126

Hospital PPO

10/2014

Welcome!

Welcome to Empire's Hospital Plan. With Empire, you have access to great coverage, flexibility and all the advantages of quality care. This benefits book explains exactly how you access health care 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 Empire Hospital Plan – A Smart Way to Get Health Care

For Fully Insured: Your Hospital Plan is a group health care plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield.

The Hospital Plan is a network of health care providers available to you through Empire. If you think about your town, it includes, hospitals, laboratories and other medical facilities that provide health care services–that's what we mean by health care "providers." Some health care providers contract with health plans like Empire to provide services to members as part of the plan's "network."

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

What's the Empire Advantage?

When you use your Empire's network to access health care, you get:

- A comprehensive web site, *www.empireblue.com* for fast, personalized, secure information
- Access to one of the largest network of 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
- Easy to use – no claim forms to file when you stay in-network
- Coverage for you and your family when traveling or temporarily 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 Empire Hospital Plan. Use it as a reference to find out what's covered, what your costs are, and how to get health care 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 HOSPITAL PLAN	13
• WHAT'S COVERED	COVERAGE	23
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	39
• HOW TO FILE A CLAIM, THE MEANING OF HEALTH CARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	50

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.

Follow These Signs

Throughout the Guide, we've posted these signs to help you out.

** 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
- Visit the Pharmacy
- Get health information and tools with My Health powered by WebMD
- Print plan documents
- Receive information through your personal "Message Center"

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

Get Personalized Health Information – Including your Health IQ

Click on MY HEALTH from your homepage 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 healthcare!
www.empireblue.com

Your Hospital Guide

Getting Answers

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 promptly addressed online quickly, simply and confidentially.

Nervous about using your PC for important health care questions or transactions? We've addressed that too! Just send us an e-mail. We will even call you back when you are available.

By Telephone

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership	**1-800-553-9603** TDD for hearing impaired: **1-800-241-6894** 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**/1-800-553-9603 Un representante de servicios a los clientes le conectará con un traductor de servicios para idiomas extranjeros que habla el idioma apropriado. 9:00 a.m. - 5:00 p.m. de Lunes - Viernes
BLUECARD® PROGRAM	• Get network benefits while you are away from home • Locate a provider outside your Empire 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 • To locate a participating behavioral health care provider in your area • Precertification of mental health and chemical dependence treatment	**1-800-553-9603** 8:30 a.m. to 5:00 p.m. Monday - Friday
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

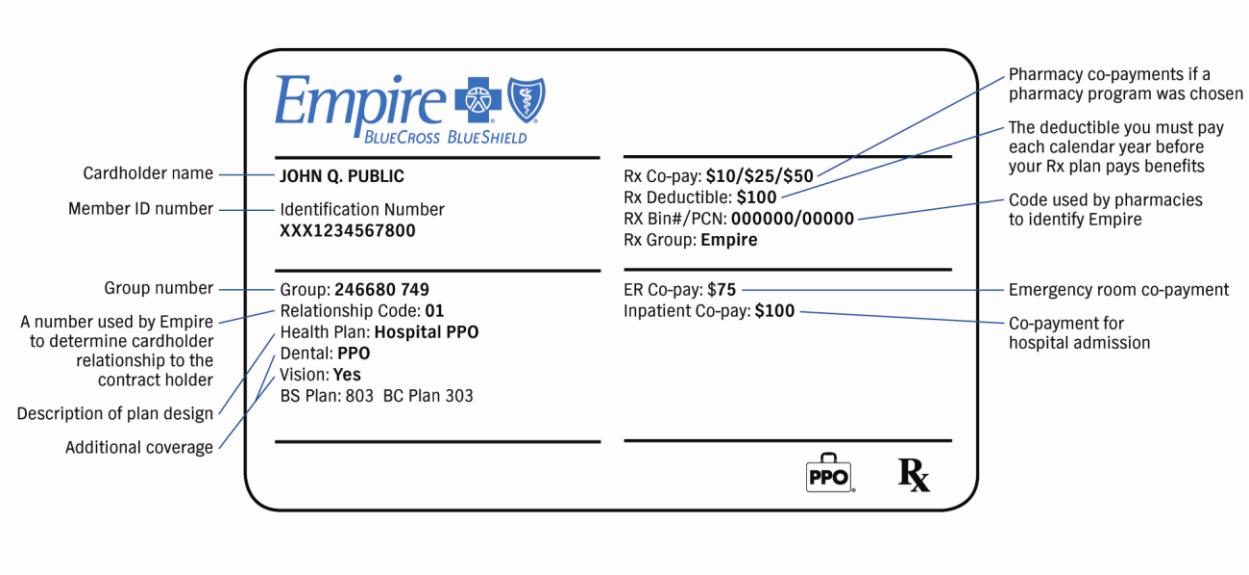
For customer service inquiries or claim submissions, you may also write to us at:

Empire BlueCross BlueShield
Hospital 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 health care as easy as possible. The Empire ID 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 health care services from a network provider. Every covered member of your family will get their own card.

The information on your card includes your name, identification number, and copayment amount for in-network hospital emergency room visits and inpatient admissions.



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

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

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

Q: Why does each family member get a separate ID 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 ID 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.

Q: Where can I get additional information?

A: Call Member Services or visit *www.empireblue.com*.

We've tried to anticipate most of your questions, but please get in touch with us if you have more specific issues.

Use Your Hospital Plan to Your Best Advantage

MEDICAL MANAGEMENT PROGRAM

Your health is valuable. Knowing how to use your Hospital Plan to your best advantage will help ensure that you receive high quality health care—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 health care. Your Hospital Plan will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the plan applies to certain types of care.

- PLEASE REMEMBER TO PRECERTIFY hospital admissions and certain treatments and procedures. 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 health care options and coverage. To find answers, you can:

  – Read this Guide.

  – Call Member Services when you have questions about your Hospital benefits in general.

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 health care you need.

Using Your Hospital Plan

Know the Basics

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

Choosing In-Network or Out-of-Network Services

In-network services are health care services provided by a hospital or health care facility that has been selected by Empire or another Blue Cross and/or Blue Shield plan to provide care to our members. When you choose in-network care, you get these advantages:

- CHOICE – You can choose any participating provider from a large network of providers in New York State or the national network of Blue Cross and/or Blue Shield PPO plans.
- BROAD COVERAGE – Benefits are available for a broad range of in-network health care services, including skilled nursing care and other services.
- CONVENIENCE – Usually, there are no claim forms to file.

Out-of-network services are health care services provided by a licensed provider outside the Empire network or the 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 available in-network only. When you use out-of-network services:

- You pay a coinsurance, plus any amount above the maximum allowed amount (the maximum Empire will pay for a covered service)
- You will need to file a claim to be reimbursed by Empire

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

	IN-NETWORK	OUT-OF-NETWORK
COPAYMENT (for emergency room)	$0	$0
COPAYMENT (for hospital inpatient admissions)	20% Coinsurance	20% Coinsurance
DEDUCTIBLE	$0	$500/Individual $1000/Family
COINSURANCE	20% Coinsurance	20% Coinsurance
ANNUAL OUT-OF-POCKET LIMIT	$2,850/Individual $5,700/Family	N/A

Where to Find Network Providers

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

Your Benefits Out-of-Area

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

Inter-Plan Programs

Out-of-Area Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Empire's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Empire and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Empire's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Empire's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Empire's Service Area

Your Liability Calculation

When covered healthcare services are provided outside of Empire's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

BlueCard® PPO Program

Nationwide, Blue Cross and Blue Shield plans have established PPO networks of hospitals and other health care providers. By presenting your Empire BlueCross BlueShield ID card to a hospital participating in the BlueCard PPO Program, you receive the same in-network benefits as you would receive from an Empire EPO network hospital. The suitcase logo on your ID 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 providers. 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 hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.
- Show your Empire BlueCross BlueShield ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as copayments, coinsurance, and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care 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 copayment and amount above the maximum allowed amount

Your Hospital Benefits At A Glance

Empire's Hospital Plan provides a broad range of benefits to you and your family. Following is a brief overview of your coverage. See the Coverage section for more details.

Some services require precertification with Empire's Medical Management Program. See the Health Management section for details.

	YOU PAY	
WELL WOMAN CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
WELL-WOMAN CARE (available only in outpatient department of hospital) • Pap smears • Mammogram (based on age and medical history) – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year	 $0 $0	 20% coinsurance 20% coinsurance
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
EMERGENCY ROOM (Call within 48 hours of admission to certify hospital stay)	$0	
OUTPATIENT HOSPITAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
DIAGNOSTIC PROCEDURES (available with MMP rider) • X-rays and other imaging • MRIs/MRAs • All lab tests	$0	20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY (BY RIDER)	$0	20% coinsurance
PRE-SURGICAL TESTING	$0	20% coinsurance
AMBULATORY SURGERY	20% Coinsurance	Deductible & 20% coinsurance
KIDNEY DIALYSIS	$0	20% coinsurance

Please refer to the Health Management section for details regarding precertification requirements.

	YOU PAY	
MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
ROUTINE NEWBORN NURSERY CARE (In hospital) (by rider)	$0	20% coinsurance
OBSTETRICAL CARE (In hospital)	$0	20% coinsurance
OBSTETRICAL CARE (In birthing center)	$0	Not Covered
IN-PATIENT HOSPITAL SERVICES*[1]	**IN-NETWORK**	**OUT-OF-NETWORK**
ANESTHESIA AND OXYGEN	$0	20% coinsurance
CARDIAC REHABILITATION	$0	20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	$0	20% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	20% coinsurance
DRUGS AND DRESSINGS	$0	20% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	20% coinsurance
INTENSIVE CARE	$0	20% coinsurance
KIDNEY DIALYSIS	$0	20% coinsurance
SEMI-PRIVATE ROOM AND BOARD	20% coinsurance	20% coinsurance
SAME DAY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
ANESTHESIA AND OXYGEN	$0	20% coinsurance
BLOOD WORK FOR EMERGENCY CARE OR AMBULATORY SURGERY	$0	20% coinsurance
SAME DAY (OUTPATIENT) SURGERY	$0	20% coinsurance

Please refer to the Health Management section for details regarding precertification requirements.

** Does not include inpatient behavioral health care or physical, occupational, speech and vision therapy/rehabilitation. See the Coverage section for a description of these benefits.*

[1] *Residential treatment services are not covered.*

	YOU PAY	
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY • Up to 60 days per calendar year	20% coinsurance	20% coinsurance
HOSPICE • Up to 210 days per lifetime	20% coinsurance	20% coinsurance
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
HOME HEALTH CARE • Up to 200 visits combined in- and out-of-network per calendar year (a visit equals 4 hours of care)	20% coinsurance	20% coinsurance only.
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICAL THERAPY AND REHABILITATION • Up to 30 days of inpatient service combined in- and out-of-network per calendar year	20% coinsurance	20% coinsurance
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
INPATIENT • Unlimited number of medically necessary days	20% coinsurance	20% coinsurance
OUTPATIENT • Unlimited number of medically necessary visits for the treatment of mental health care in a facility-based program	$0	
CHEMICAL DEPENDENCE	**CHEMICAL DEPENDENCE**	**OUT-OF-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits , including visits for family counseling	$0	20% coinsurance
INPATIENT • Unlimited number of medically necessary days of detoxification for chemical dependence	20% coinsurance	20% coinsurance
• Unlimited number of medically necessary rehabilitation days	$0	20% coinsurance

Please refer to the Health Management section for details regarding precertification requirements.

Coverage

Emergency Care

If You Need Emergency Care

Should you need emergency care, your Empire Hospital 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 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. With respect to an emergency medical condition, the term "Stabilize" means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta).

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.

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 network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a copayment for a visit to an emergency room. This copayment is waived if you are admitted to the hospital within 24 hours.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition.

You will need to show your Empire BlueCross BlueShield ID card when you arrive at the emergency room.

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 ID card at the emergency room. 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 ID 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.

Please refer to the Health Management section for details regarding precertification requirements.

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 or air ambulance

Maternity Care

If You Are Having a Baby

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.

Please refer to the Health Management section for details regarding precertification requirements.

Covered services are listed in Your Hospital PPO 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 time frame. The visit will take place within 24 hours after either the discharge or the time of the request, whichever is later
- Parent education, and assistance and training in breast or bottle feeding, if available
- Hospital services for circumcision of newborn males
- Special care for the baby if the baby stays in the hospital longer than the mother.
- Semi-private room
- Routine nursery care for well newborn is covered for up to 30 days during the mother’s medically necessary confinement. (routine nursey care rider

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

Use a network hospital or facility to receive the lowest cost maternity care.

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).

Hospital Services

If You Visit the Hospital

Your Hospital Plan covers most or all 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 coinsurance, plus any amount above Empire's maximum 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.

Please refer to the Health Management section for details regarding precertification requirements.

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 with Empire.

Tips for Getting Hospital Care

- If your doctor prescribes pre-surgical testing 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.

Outpatient Hospital Care

Covered services are listed in Your Hospital Benefits At A Glance. Following are additional covered services and limitations when performed in the outpatient (same-day) care department:

- Diagnostic procedures and lab tests
- Blood and blood derivatives. For emergency care, ambulatory surgery
- MRIs/MRAs
- Cervical cancer screenings. This includes a pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.
- Mammogram (based on age and medical history)
  - Ages 35 through 39 – 1 baseline
  - Age 40 and older – 1 per year
- Same-day and hospital outpatient surgical facilities
- Chemotherapy and radiation therapy, including medications, in a hospital outpatient department or facility. Medications that are part of outpatient hospital treatment if they are prescribed by the hospital and filled by the hospital pharmacy.
- Physical, Occupational, Speech and Vision Therapy, in a hospital outpatient department or facility up to 30 visits per calendar year.
- 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 facility
  - In a free-standing facility

See “hospital/facility” in the Definitions section.

Please refer to the Health Management section for details regarding precertification requirements.

Outpatient Hospital Care

These outpatient services are not covered:

- Same-day surgery that requires the use of an outpatient department of a hospital or ambulatory facility not **precertified** as medically necessary by the 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

Inpatient Hospital Care

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 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 (if their services are included in hospital charges)
- 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
- Inpatient physical, occupational, speech and vision therapy including facilities
- Chemotherapy and radiation

Please refer to the Health Management section for details regarding precertification requirements.

Inpatient Hospital Care

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 semi-private room. The additional cost cannot be applied to your 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 or for a rest cure or convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment.
- There are no benefits for care in a hospital, or in a separate division of a hospital, where half or more of the days of care provided by that hospital or that separate division of the hospital are during stays of more than 90 days in length
- Hospitalization or treatment of cosmetic surgery. However, cosmetic surgery shall not include reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or reconstructive surgery of the breast, when a mastectomy has been performed, including surgery and reconstruction of the other breast to produce a symmetrical appearance. For a covered child, benefits are available for cosmetic or reconstructive surgery for a functional defect which is caused by a congenital disease or anomaly.
- 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.
- Residential treatment services are not covered.

Skilled Nursing and Hospice Care

Hospice Care available by rider

If You Need Skilled Nursing or Hospice Care

You receive full coverage through Empire's Hospital Plan for inpatient care in a skilled nursing facility or hospice. Benefits are available for in-network/ and out-of-network facilities. Benefits are available in a facility that has a participating agreement with Empire or another Blue Cross or Blue Shield Plan or in a facility that is approved by the Joint Commission of Accreditation of Healthcare Organizations.

Please refer to the Health Management section for details regarding precertification requirements.

Skilled Nursing Care

You are covered for up to 60 inpatient days per calendar year in a network skilled nursing facility if you need medical care, nursing care or rehabilitation services when such care is, in our judgment, medically necessary and appropriate. 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 health care professional.

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's Hospital Plan 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 participating hospital, or at home, as long as it is provided by a participating hospice agency. Hospice care is available in-network only/in-network and out-of-network.

Covered hospice care services, include:

- 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 case worker to refer to the Health Facilities Directory.
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time.

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 full coverage when you use an in-network provider. For out-of-network home health care, you pay a coinsurance. Out-of-network agencies must be certified by New York State or have comparable certification from another state.

Empire participating home health care agency cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-800-342-9816.

Covered services and limitations:

- Up to 200 home health care visits per calendar year, combined in- and out-of-network. A visit is defined as up to four hours of care. Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:
  - Nursing care

    Intermittent or part-time home nursing care. The care must be provided by or under the direct supervision of a registered nurse
  - Intermittent or part-time care provided by home health aids. Four hours of care equals one home care visit.
  - Rehabilitation care

    Physical, speech or occupational therapy provided by the home health agency
  - Medical needs

    Medical supplies, drugs and medications prescribed by a physician and laboratory services provided by or on behalf of a home health agency to the extent services would be covered if the covered member was in a hospital or a Skilled Nursing Facility as defined by Medicare.

The following home health care services are not covered:

- Custodial services, including bathing, feeding, changing or other services that do not require skilled care

Physical, Occupational, Speech or Vision Therapy

If You Need Therapy

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

Please refer to the Health Management section for details regarding precertification requirements.

Tip for Receiving Therapy

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

Outpatient Services

Following are 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

  Outpatient care must be given in an outpatient facility; 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 in an outpatient facility,
  - Performed by a licensed speech/language pathologist or audiologist, and
  -

The following therapy services are not covered:

- Therapy to maintain or prevent deterioration of the patient's current physical abilities

Behavioral Health Care

If You Need Behavioral Health Care

At Empire we realize that your mental health is as important as your physical health. Your behavioral health care benefits cover outpatient treatment for chemical dependence (includes alcohol and substance abuse) both in-network and out-of-network.

Inpatient chemical dependence detoxification is covered for an unlimited number of medically necessary in-network and out-of-network days of detoxification.

Inpatient chemical dependence rehabilitation is covered in a facility, in-network and out-of-network, for an unlimited number of medically necessary rehabilitation days.

Mental health care is covered on an inpatient basis in-network and out-of-network for an unlimited number of medically necessary inpatient care days and facility-based outpatient care visits.

The Hospital Benefits at a Glance section gives an overview of your behavioral health care benefits. Treatment maximums are combined for in-network and out-of-network care.

Please refer to the Health Management section for details regarding precertification requirements.

Mental Health Care

The following mental health care service are covered:

- Electroconvulsive therapy in the hospital or psychiatric facility for treatment of mental or behavioral disorder
- 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.
- Outpatient mental health care
- 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.

Treatment for Chemical Dependence

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 pursuant to Article 32 of the New York State Mental Hygiene Law
  - 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.

The following chemical dependence treatment services are not covered:

- Out-of-network outpatient chemical dependence treatment at a facility that does not meet certification requirements as stated above
- Care that is not medically necessary

Exclusions and Limitations

Exclusions

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

Dental Care

Benefits will not be provided for dental care or treatment However, we will provide covered benefits for services necessary due to an accidental injury to sound natural teeth rendered within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly is covered.

Experimental/Investigational Treatments

- Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, or when requested by an external appeal agent, Empire will not cover any treatment, procedure, drug, biological product or medical device or any hospitalization in connection with such technology if, in Empire's discretion, it is determined that such technology is experimental or investigational, unless otherwise recommended by an External Appeal agent.

  "Experimental" or "investigative" means that for the technology is:
  - Not of proven benefit for the particular diagnosis or treatment of the covered member's particular condition, or
  - Not generally recognized by the medical community as reflected in published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.
  - We will also not cover any technology or any hospitalization in connection with such technology if, in Empire's discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the covered person's particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a covered person's condition. Empire may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, (e.g. investigational device exemption or an investigational new drug exclusion, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require any or all of the five criteria be met.

- Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, withy measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- Demonstrated evidence as reflected in the published peer-review medical literature must exist that over time the technology leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

However, your plan will cover an experimental or investigational treatment approved by a New York certified External Appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Empire will only cover the costs of services required to provide treatment to you according to the design of the trial. Empire shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or cost which would not be covered under this plan for non-experimental or investigational treatments.

Government Hospital Services

- Services covered under government programs, except Medicaid or where otherwise noted
- Government hospital services, except:
  - Specific services covered in a participation agreement or special agreement between Empire and a government hospital
  - United States Veteran's 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

Limit on Payment

- We will not pay an amount that is more than a provider charged for covered care or that is more than the maximum allowed amount, nor will we credit such an amount toward the coinsurance.

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

Non-Acute or Chronic Hospital Care

- There are no benefits for any part of a hospital stay that is primarily custodial or for a rest cure or for convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment. There is no coverage for care in a hospital, or in a separate division of a hospital, where half or more of the days of care provided by that hospital, or that separate division of the hospital, are during stays of more than ninety (90) days in length.

Prescription Drugs

- All prescription drugs and over the counter drugs, which do not require a prescription, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated.

Services By Unlicensed Providers

- Any services provided by an unlicensed provider or services that are outside the scope of the license of the licensed provider who provided them are not covered.

Services Provided Pursuant to a Prohibited Referral

- 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.

Sterilization/Reproductive Technologies

- Reversal of sterilization
- Assisted reproductive technologies including but not limited to:
  - In-vitro fertilization
  - Artificial insemination
  - Gamete and zygote intrafallopian tube transfer
  - Intracytoplasmic sperm injection

Travel

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

Vision Care

- Eyeglasses, contact lenses and the examination for their fitting except following cataract surgery, unless specifically indicated.

War

- Services for illness or injury received as a result of war, declared or undeclared, or any act of war.

Workers' Compensation

- Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs unless and until the covered person has exhausted all of the benefits under these laws. This applies even if the covered person does not claim benefits under the above laws or policies or after any of the above benefits are paid, the covered person must repay them because he recovers that money in a lawsuit or other proceeding.

Limitation as Independent Contractor

The relationship between Empire 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.
- 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 health care services on the following page 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 • Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification • Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs • Occupational, Vision, Speech and Physical Therapy • Outpatient/ Ambulatory Surgical Treatments (certain procedures) • Diagnostics • Outpatient Treatments

If Services Are Not Precertified

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $5,000 for each admission or each visit. This benefit reduction also applies to same-day surgery and professional services rendered during an inpatient admission. If the admission or procedure is not medically necessary, no benefits will be paid.

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

Approval or denial of certification of services will be provided to you, your doctor and the hospital, by telephone or in writing, within three business days once all necessary information is received. Before they notify you, your doctor or any other providers to discuss the treatment, the Medical Management Program will review all necessary medical records and information. If you or your provider disagrees with a Medical Management decision, you may request an appeal.

Case Management

If You Need Additional Support for Serious Illness

The Medical Management Program's Case Management staff can provide assistance and support when you or a member of your family faces a chronic or catastrophic illness or injury. Staff nurses can help you and your family:

- Find appropriate, cost-effective health care options
- Reduce medical costs
- Help assure access to quality medical care

A Case Manager serves as a single source for patient, provider, and insurer – helping to assure that the treatment, level of care, and facility are appropriate for your needs. For example, Case Management can help with cases such as:

- Cancer
- Stroke
- AIDS
- Chronic illness
- Hemophilia
- Spinal cord and other traumatic injuries

Assistance from Case Management is evaluated and provided on a case by case basis. In some situations, the Medical Management Program staff will initiate a review of a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the Hospital Plan is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact the Medical Management Program at 1-800-982-8089.

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 health care terms

Knowing the details can make a difference in how satisfied you are with your Hospital Plan, and how easy it is for you to use. If you have additional questions, please call Member Services at 1-800-342-9816 or 1-800-553-9603.

Eligibility

When Are You Eligible?

Your coverage under Empire's Hospital Plan begins on

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

Contact your Benefits Administrator/Fund Office for more information on eligibility rules.

Coverage Category

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

- Individual, which covers only you
- Husband and wife, which covers you and your spouse
- Parent-Child/Children, which covers you and your dependent children
- Two-person, which covers you and your spouse or you and one dependent child
- Family, which covers you and one or more of the following:
  - Your spouse
  - Dependent children (natural or adopted)

Eligible Dependents

The following family members are eligible for coverage:

- Your spouse - an opposite sex or same-sex spouse to a marriage that is legally recognized in the jurisdiction (State or Country) in which it is performed. Former spouses, as a result of a divorce or annulment of a marriage, are not considered eligible spouses.
- Your children, including natural children, legally adopted children, stepchildren, and child of your domestic partner, until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered.
- Your unmarried children, regardless of age, who are incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap, and who became so incapable prior to attainment of the age at which the dependent coverage would otherwise terminate.
- Your domestic partner. Please check with your Benefits Administrator for more information.

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, or having your children no longer meet the eligibility requirements. The following circumstances may result in changes to your coverage:

- If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the 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 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 eligible for coverage under this program if the following enrollment conditions are met:
  - You or eligible dependent was covered under another plan at the time coverage was initially offered, and
  - Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
  - Contract holder contributions toward the payment of premium for the other plan were terminated, 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
    - An employer no longer offers benefits to a class of indivuduals (i.e., part time workers)
    - Legal separation, divor
    - Reduction in the numb
    - Premium payments for
    - Lifetime maximum be

  The eligible group member, member's spouse and eligible dependents who have not been covered under other group coverage, are eligible for a special enrollment period following marriage, a birth, adoption or placement for adoption.

  Coverage must be applied for within 60 days of one of the qualifying special enrollment events described above.
- If you marry and transfer to two-person /husband and wife or 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.
- Eligible Employees and Dependents may also enroll under two additional circumstances:
  - the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
  - the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

  The Employee or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination.

- Enrolling a newborn child:
  - For a Member who has individual (for self only), employee\spouse, or parent\child (two-person) coverage:
    - 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.
    - He\she MUST formally add his\her **eligible** 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.
    - 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**.**
    - If you do not switch to a parent\child, parent\children, or family contract and enroll your **eligible** newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Plan**.**
  - For a Member who has family or parent\children (more than two person) coverage:
    - An **eligible** newborn child, or a proposed adopted newborn, will be covered from the date of birth**.**
    - He\she MUST formally add his\her **eligible** 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.
    - Coverage will still be effective from the date of birth for an **eligible** 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.
    - Any claims for an **eligible** 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**.**
- 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 within 31 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

– 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 an employee.

You may request, without charge, the procedures governing the administration of a Qualified Medical Child Support Order determination from your Plan Administrator. Your Plan Administrator will notify Empire to process the enrollment for the covered person.

Claims

If You Need to File a Claim

Empire's Hospital Plan makes health care 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	You or the provider files claim with Empire or local Blue Cross/Blue Shield plan*

* *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.*

Hospital Claims

Send completed forms to:

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

Assignment

You authorize Empire, on behalf of the Employer, to make payments directly to participating In-Network Providers for Covered Services. Empire also reserves the right to make payments directly to you. Except where Empire expressly indicates otherwise, in the case of services provided by an out of network provider, payments will always be made directly to you for services provided by the out of network provider. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Empire will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state or Federal law.

Once a Provider performs a Covered Service, Empire will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

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 1-800-342-9816/1-800-553-9603 to have one mailed to you.
- Complete all of the information requested on the claim 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.

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

If You Have 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 group health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other group health 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 group health 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 provision, 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 and the parents are not separated or divorced, 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
- For a dependent child covered under both parents' plans, the parents are divorced or separated and there is no court decree establishing financial responsibility for the child's health care 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 health care expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are covered under one plan as an active employee, or as the dependent of an active employee, and are also covered under another plan as a laid-off or retired employee or as the dependent of a laid-off or retired employee, the plan which covers you as an active employee, or as the dependent of an active employee, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which is primary, this rule will be ignored.
- 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 maximum allowed amount. 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 and Reimbursement

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan may have the right to recover payments it makes on your behalf from a party responsible for compensating you for your illnesses or injuries, as permitted by applicable law. When a right to recovery exists, the following will apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery, as permitted by applicable law, in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery

(e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, as permitted by applicable law, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery, as permitted by applicable law. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  - The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  - You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan, as permitted by applicable law.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, to the extent permitted by applicable law, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, to the extent permitted by applicable law, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan, to the extent permitted by applicable law.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Subrogation

(INCLUDE FOR FULLY INSURED ONLY)
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 health care. Empire welcomes your help in fighting fraud. If you know of any person who is receiving Empire BlueCross BlueShield benefits that they are not entitled to, call us. We will keep your identity confidential.

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 copayment 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 including your right to appeal a claim decision for any reason other than a denial based on medical necessity or experimental or investigational.

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 1-800-342-9816/1-800-553-9603 or in writing for more information. When you call, be sure to have your Empire ID card number handy, along with any information about your claim.

Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (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.

Reimbursement for Covered Services

MAXIMUM ALLOWED AMOUNT

This section describes how We determine the amount of reimbursement for Covered Services. Providers who have entered into an agreement with Empire to participate in Our provider network or who have agreed to render services to covered persons under Your Plan are referred to in this Rider as Participating Providers. Providers who have not signed any contract with Us and are not in any of our networks are referred to as Nonparticipating Providers.

Reimbursement for services rendered by Participating and Nonparticipating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the Blue Cross and Blue Shield Association BlueCard Program section/Rider for additional information regarding services received outside of Empire's service area.

The Maximum Allowed Amount is the maximum amount of reimbursement Empire will pay for services and supplies:

- that meet the definition of services and supplies that are covered under Your Plan and are not excluded ("Covered Services");
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Medical Management Programs or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met any applicable Deductible, Copayment or Coinsurance. In addition, when you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing and reimbursement rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means We have determined that the claim submitted was inconsistent with procedure coding rules and/or our reimbursement policies.

For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Nonparticipating Provider.

For Covered Services performed by a Participating Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they are prohibited by contract from sending you a bill, or otherwise attempting to collect amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible, or have a Copayment, Coinsurance, or other form of cost share under the terms of Your Plan. Please call Customer Service for help in finding a Participating Provider or visit *www.empireblue.com*.

For Covered Services that you receive from a Nonparticipating Provider, the Maximum Allowed Amount will be based on our Nonparticipating Provider fee schedule/rate or the Provider's charge, whichever is less. Our Out-of-Network Provider fee schedule/rate may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount on our Nonparticipating fee schedule/rate has been developed by reference to one or more of several sources, including the following:

1. Amounts based on our Participating Provider fee schedule/rate;
2. Amounts based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated no less than annually;
3. Amounts based on charge, cost reimbursement or utilization data;
4. Amounts based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care; or
5. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.

Providers who are not contracted for this Plan, but contracted for other Plans with Us, are also considered Nonparticipating. The Maximum Allowed Amount reimbursement for services from these Providers will be based on Our Nonparticipating Provider fee schedule/rate as described above unless the contract between Us and that Provider specifies a different amount.

Unlike Participating Providers, Nonparticipating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding Participating Providers or visit our website at *www.empireblue.com*.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Nonparticipating Provider. In order for Us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

MEMBER COST SHARE

For certain Covered Services and depending on Your Plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment and/or Coinsurance).

Your cost share amount and annual out-of-pocket limitmay vary depending on whether you received services from a Participating or a Nonparticipating Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Nonparticipating Providers. Please see the terms of this Certificate and the Schedule of Benefits for your cost share amounts and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of Provider you use.

Empire will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services regardless of whether such services are performed by a Participating Provider or a Nonparticipating Provider. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your lifetime maximum, benefit caps, or day/visit limits. Note that no coverage is available for services provided by Nonparticipating Providers if Your Plan requires the services to be provided only by Participating Providers.

In some instances you may only be asked to pay the lower cost sharing amount that applies to Participating Provider services when you use a Nonparticipating Provider. For example, if you go to an Participating Hospital or Facility and receive Covered Services from a Nonparticipating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or Facility, to the extent you have coverage for those services, you will pay the cost share amounts that apply to Participating Providers for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge.

AUTHORIZED SERVICES

In some circumstances, such as where there is no Participating Provider available for the Covered Service, We may authorize the cost share amounts that apply to Participating Provider services (such as Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Nonparticipating Provider. In such circumstance, you must contact Us in advance of obtaining the Covered Service. We will also authorize the cost share amounts that apply to Participating Provider services if you receive Emergency services from a Nonparticipating Provider. If We authorize Covered Services from a Nonparticipating Provider so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge. Please contact Customer Service for information or to request authorization.

Complaints, Appeals and Grievances

An appeal is a request to review and change an adverse determination made when (i) Empire's Medical Management Program (MMP) or Mental and Behavioral Health Care Manager (MBHCM) determines a service is not Medically Necessary, or is excluded from coverage because it is considered Experimental or Investigational; or (ii) if we deny a claim, wholly or partly, for services already rendered, based on our utilization review process.

In the event that Empire renders an adverse determination without attempting to discuss such matter with the Covered Person's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the Covered Person's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, Empire shall provide notice as required pursuant to subsection 3 of this Section. Nothing in this Section shall preclude the Covered Person from initiating an appeal from an adverse determination.

Failure by Empire to make a determination within these described time periods shall be deemed to be an adverse determination subject to appeal rights pursuant to the standard and expedited appeal process of Section 4904 of the New York State Insurance law, described below

STANDARD LEVEL 1 APPEALS

The Covered Person (or the Covered Person's authorized representative, or health care provider) may file a formal appeal by telephone or in writing. An appeal must be filed within one hundred, eighty (180) calendar days from the date of receipt of notice of a denial of services. An appeal submitted beyond the one-hundred, eighty (180) day filing limit will not be accepted for review.

Empire will send written notice of acknowledgement of the appeal within fifteen (15) days of receipt of that appeal to the Covered Person or the Covered Person's authorized representative. The appeal will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination. A final determination will be made within the following timeframes after receiving all necessary information or medical records related to the appeal request:

- 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.

Empire will provide a written notice of our determination to the Covered Person or the Covered Person's representative, and Provider within two (2) business days of reaching a decision. The decision will include the reason(s) for the determination, including the clinical rationale if the adverse determination is upheld, date of service, claim amount (if applicable), diagnosis code and treatment code, and corresponding meaning of these codes. The notice will specify that you may request a copy of the clinical review criteria used to make the determination. The notice will also specify what, if any, additional necessary information must be provided to or obtained by Empire in order to render a decision on appeal and an explanation of why the information is necessary. The notice will also advise you of your right to appeal our determination, give instructions for requesting a standard or expedited internal appeal and initiating an external appeal.

If Empire does not make a decision within sixty (60) calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

In addition, if the groups is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Group members have certain rights and protections and the group may have duties as the Group Health Plan Administrator. Among them is the right to appeal a claim decision. Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision.

The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

EXPEDITED LEVEL 1 APPEALS

Empire will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

i. Continuations or extensions of health care services, procedures or treatments already begun;
ii. Additional required or provided care during an ongoing course of treatment; or
iii. A case in which the Provider believes an immediate appeal is warranted; or
iv. When home health care is requested following discharge from an inpatient hospital admission.

When requested under these circumstances, the following time frames will apply:

- Empire will provide the Covered Person or his Provider with reasonable access to our clinical reviewer within one (1) business day of receiving a request for an expedited appeal. The Provider and clinical peer reviewer may exchange information by telephone or fax.
- Empire will make a decision on an expedited appeal within the lesser of seventy-two (72) hours of recept of the appeal request or two (2) business days following receipt of all necessary information about the case, but in any event within seventy-two (72) hours of receipt of the appeal.
- Empire will notify the Covered Person and his Provider immediately of the decision by telephone and will transmit a copy of the decision in writing within twenty-four (24) hours after the decision is made.
- If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection, or through an external appeal agent if the appeal is based on Medical Necessity or Experimental or Investigational denials. The notice of appeal determination will include the time frame for external appeals as required by 4904 (C)(2) of the New York State Insurance Law.
- If Empire does not make a decision within two (2) business days of receiving all necessary information to review the Covered Person's appeal, Empire will approve the service.

STANDARD LEVEL 2 APPEALS

If the Covered Person is dissatisfied with the outcome of the Level 1 Appeal, a Level 2 Appeal may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the 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 or in writing.

We will make a decision within the following timeframes for Level 2 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.

HOW TO REQUEST AN APPEAL

To submit an appeal, call Member Services at the telephone number located on the back of your identification card, or write to the applicable address(es) listed below. Please submit any data to support your request and include your member identification number and if applicable, claim number and date of service.

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

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

External Appeals

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination That a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered);or

- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

The External Appeal Process

If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with the subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

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 health care 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 Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
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.

LEVEL 1 GRIEVANCE

A grievance is a verbal or written request for a review of an adverse determination concerning an administrative decision not related to medical necessity.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have one-hundred, eighty (180) calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the one-hundred, eighty (180) calendar day limit will not be accepted for review.

If the services have already been provided, Empire will acknowledge your grievance in writing within fifteen (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, 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 fifteen (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 thirty (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 sixtieth (60^{th}) 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 2^{nd} Level Grievance within fifteen (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 2^{nd} Level Grievances:

- *Pre-service*. We will complete our review of a pre-service grievance within fifteen (15) calendar days of receipt of the grievance.
- *Post-service*. We will complete our review of a post-service grievance within thirty (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 seventy-two (72) hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two (2) 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 A GRIEVANCE

To submit an appeal or grievance, call Member Services at the telephone number located on the back of your ID card, 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.

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

Send appeals concerning behavioral health care to:

Grievances and Appeals – Behavioral Health
P.O. Box 2100
North Haven, CT 06473

HOW YOU CAN PARTICIPATE IN POLICY DEVELOPMENT

We welcome your input on policies that we have developed or you would like us to initiate. If you wish to share any ideas with us, we encourage you to write to us at:

Empire Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

We will forward your ideas to the department responsible for developing the type of policy involved, and your suggestions will be reviewed and considered. You will then receive a response to your comments. In addition, we review member complaints, member satisfaction information, new technology, and new procedures to determine if changes should be made to your benefits.

PROVIDER QUALITY ASSURANCE

Because your health care 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 Member Services address above.

Ending and Continuing Coverage

When Coverage Ends

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

- Your group/fund terminates the contract
- Your employer/fund no longer meets our underwriting standards
- Your employer/fund fails to pay premiums
- You fail to pay premiums (if required)
- The covered employee/member dies
- You or your covered dependents no longer meet your employer's/Fund'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

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.

What is continuation coverage?

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 Plan Sponsor or the Group Benefits Administrator for your group.

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 Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration, 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 Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration for your group.

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 less than 20 employees), you may be entitled to continue coverage under New York State Law. Call or write to your employer/fund to find out if you are entitled to continuation of coverage under the New York State Insurance Law.

Converting Your Coverage

(USE FOR ASO GROUP ONLY:) Under certain circumstances, you may convert your group coverage to individual coverage with comparable benefits if such coverage is available from your group Or, you may 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. Please see your Benefits Administrator for details.

DELETE ENTIRE SECTION BELOW FOR ASO GROUPS

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

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

In addition to all the rights of conversion and continuation otherwise provided, employees or members insured under the contract who are also members of the reserve component of the armed forces of the United States, including the National Guard, will be entitled to have supplementary conversion and continuation rights in certain circumstances as follows:

- If a 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 member and their eligible 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 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.

If the group's plan qualifies as an employer group health plan/fund, subject to the federal continuation of coverage provision of COBRA, as described in the contract, the supplementary conversion and continuation rights previously described do not apply.

To request an application or obtain additional information, 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.

Certificates of Creditable Coverage After Termination

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of coverage must be issued to a Member and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members within a reasonable amount of time after Empire has terminated membership. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

If You Become Disabled

If you or your covered dependent is 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 twelve 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 are 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 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, and
- You are an active employee
- 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.

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 Program

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 health care 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, cost share maximum, 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 Rights As A Hospital Plan Member

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. 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 1-800-342-9816/1-800-553-9603. 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
Director, New York Regional Office
33 Whitehall Street, Suite 1200
New York, NY 10004
Telephone: 1-212-607-8600
Fax: 1-212-607-8681
Toll-Free: 1-866-444-3272

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 [DELETE IF GROUP HAS NO RX COVERAGE]
- A directory of participating providers free of charge
- 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 whose 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.

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.
- The member has the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person acting on the member's behalf.

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

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.

Definitions

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

Adverse Determination A communication from Empire 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 Limit The most you pay during a Benefit Period in cost sharing before your Plan begins to pay 100% of the Maximum Allowed Amount for Covered Services. The Annual Out-of-Pocket Limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for services that your Plan does not cover. The Annual Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Benefits in Detail" section for cost shares that apply to Your Plan.

Authorized Services See "precertified services."

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

Copayment The fee you pay when you are admitted to in-network facilities. The plan then pays 100% of remaining covered expenses.

Covered Services The services for which Empire provides benefits under the terms of your contract.

Hospital For chemical dependence treatment 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.

Hospital/Facility

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 BlueCross BlueShield, 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 BlueCross BlueShield, 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 health care 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 health care services. For chemical dependence treatment 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 BlueCross BlueShield

Empire's Hospital Plan 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; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

In-Network Benefits

Benefits for covered services delivered by in-network hospital facilities.

In-Network Provider/Supplier

A hospital, facility or home health care agency who:

- Is in Empire's Hospital 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 hospital or ambulance service, which gives information that Empire needs to settle your claim. Hospital bills will contain the patient's name, diagnosis, and date and charge for each service performed. 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.

Maximum Allowed Amount (MAA)

The maximum dollar amount of reimbursement for Covered Services. Please see the Maximum Allowed Amount Reimbursement for Covered Services section for additional information.

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 BlueCross BlueShield, or another Blue Cross and/or Blue Shield plan to provide services to persons covered under the Empire Hospital 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 BlueCross BlueShield 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 hospital and facilities.

Out-of-Network Providers/Suppliers

A hospital, facility or home health care agency who:

- Is not in Empire's 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."

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 the Medical Management Program to be fully covered by your plan. Failure to precertify, may result in a reduction or denial of benefits.

Provider

A "hospital/facility or home health care agency or skilled nursing facility.

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.

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

   (1) 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

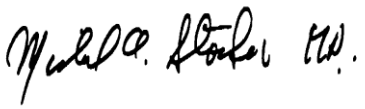
(3) Empire provides the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

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:

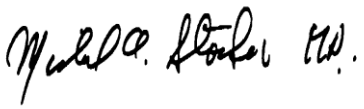
    At the time of coverage renewal only, Empire may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law, and effective on a uniform basis among all small group contract holders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