Empire's PPO for United Nations Group 374610-A

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11/2003

Welcome!

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

Your PPO – A Smart Way to Get Health Care

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

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

What's the Empire PPO Advantage?

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

- A comprehensive Web site, *www.empireblue.com*, for fast, personalized, secure information
- Among the largest network of doctors and hospitals in New York State
- Providers that are continuously reviewed for Empire's high standards of quality
- The ability to choose in-network or out-of-network care for most covered services
- Minimal out-of-pocket costs for preventive care, behavioral health care and a wide variety of hospital and medical services when you stay in-network
- Easy to use – no claim forms to file when you stay in-network
- Coverage for you and your family when traveling or 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 PPO. Use it as a reference to find out what's covered, what your costs are, and how to get healthcare services any time you or a covered family member need them.*

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

IF YOU ARE LOOKING FOR …	YOU'LL FIND IT IN	ON PAGE
• HOW THE PLAN WORKS	USING YOUR PPO	11
• WHAT'S COVERED	COVERAGE	19
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	55
• HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	63

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 and resolve claims
- Search for doctors and specialists
- Update your member profile
- Access pharmacy information and services
- 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*
- Follow the simple registration instructions

Assistance Is a Click Away

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

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

Get Personalized Health Information – Including Your Health IQ

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

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

Your Privacy Is Protected

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

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

Your PPO Guide

Introduction

Using Your PPO

Coverage

Health Management

Details and Definitions

Getting Answers Your Way

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

On the Internet

Do you have customer service inquiries and need an instant response? Visit *www.empireblue.com.*

At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially.

Nervous about using your PC for important healthcare questions or transactions? We've addressed that too! Just "click to talk" to a representative or send us an e-mail.

By Telephone

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership	**1-800-342-9816** TDD for hearing impaired: 1-**800-241-6895** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanesca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor. 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	• Get network benefits while you are away from home • Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** ***www.bcbs.com*** 24 hours a day, 7 days a week

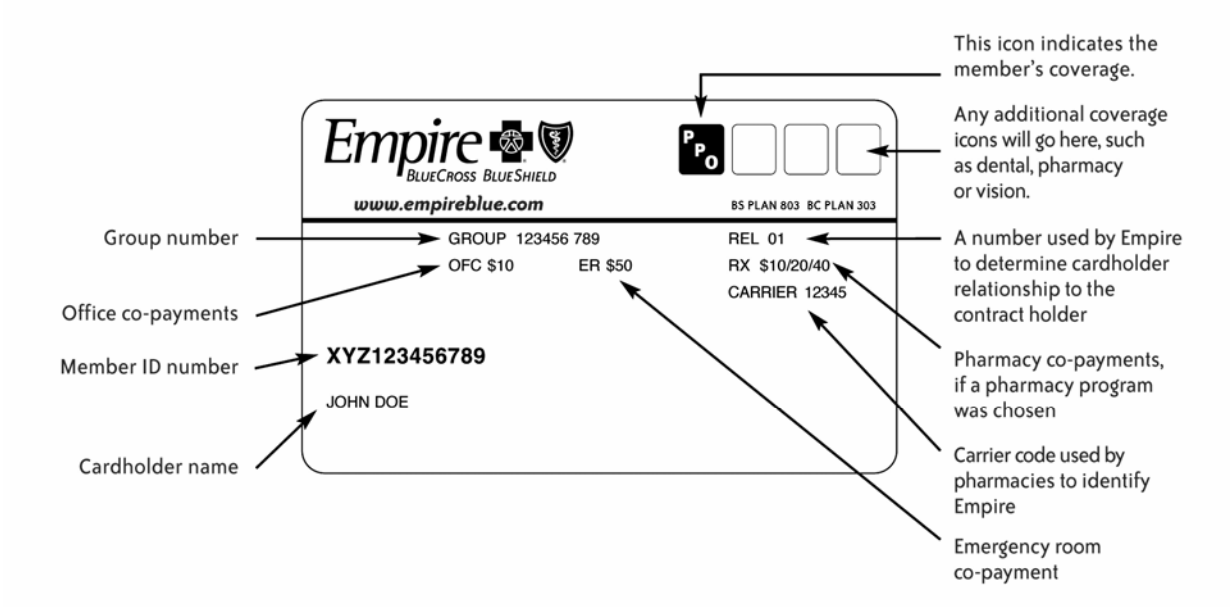
WHAT	WHY	WHERE
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday -– Friday
EMPIRE HEALTHLINE℠	Speak with a specially trained nurse to get health information	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
BEHAVIORAL HEALTH CARE MANAGEMENT	• To locate a participating behavioral health care provider in your area • Precertification of mental health and alcohol/substance abuse care	**1-800-626-3643** NON-EMERGENCY CARE 8:30 a.m. to 5:00 p.m. Monday –- Friday EMERGENCY CARE 24 hours a day, 7 days a week
EMPIRE PHARMACY MANAGEMENT PROGRAM	• Information about the program • Locate a participating retail pharmacy • Obtain a complete drug formulary list	**1-800-342-9816** TDD for hearing impaired: **1-800-241-6895** 7:00 a.m. to 10:00 p.m. Monday –- Friday 9:00 a.m. to 9:00 p.m. Saturday 9:00 a.m. to 5:30 p.m. Sunday
VISION CARE	To find a participating vision care provider in your area	**1-888-EYE-BLUE (393-2583)** 8:00 a.m. to 8:00 p.m. Monday –- Friday 9:00 a.m. to 4:00 p.m. Saturday
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

In Writing

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

Your Identification Card

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



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

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

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

Q: What do the icons in the upper right hand corner of the card mean?

A: The icons are illustrations of the plan(s) that you've enrolled in. The first icon shows that you're enrolled in the PPO. The other icons show which additional plans or programs you are enrolled in – pharmacy, dental or vision. It's easy to see what coverage you have!

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

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

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

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

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Use Your PPO To Your Best Advantage

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

- BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.

- PLEASE REMEMBER TO PRECERTIFY hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. You'll recognize these services when you see this sign. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care – for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.

- ASK QUESTIONS about your healthcare options and coverage. To find answers, you can:

  – Read this Guide.

  – Call Member Services when you have questions about your PPO benefits in general or your benefits for a specific medical service or supply.

  – Call Empire HealthLine℠ – available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.

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

Using Your PPO

Know the Basics

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

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

Choosing In-Network or Out-of-Network Services

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

- CHOICE – You can choose any participating provider from the largest network of doctors and hospitals in New York State or the national network of Blue Cross and Blue Shield PPO plans.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a small copayment for office visits and many other services.
- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- CONVENIENCE – Usually, there are no claim forms to file.

Out-of-network services are healthcare services provided by a licensed provider outside Empire's PPO network or the PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:

- You pay an annual deductible and coinsurance, plus any amount above the allowed amount (the maximum Empire will pay for a covered service)
- You will usually have to pay the provider when you receive care
- You will need to file a claim to be reimbursed by Empire

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

	IN-NETWORK	OUT-OF-NETWORK
PROVIDER'S CHARGE	$500	$500
ALLOWED AMOUNT	$400	$400
PLAN PAYS PROVIDER	$390	$320 (80% of allowed amount)
YOU PAY PROVIDER	$10 copayment	$180 (20% of allowed amount, plus the $100 above the allowed amount. Assumes you have satisfied your deductible)

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

	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE*	$0	$150/Individual $450/Family
COPAYMENT (for office visits and certain covered services)	$10 per visit	N/A
COPAYMENT (for hospital inpatient admissions)	$0	N/A
COPAYMENT (for emergency room)	$35 per visit (waived if admitted to hospital within 24 hours)	$35 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	$0	You pay 20% of allowed amount. Plan pays 80% of allowed amount
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	N/A	$1,000/Individual $2,500/Family
LIFETIME MAXIMUM	Unlimited	Unlimited

* *If you had group coverage under a major medical or extended medical plan with Empire prior to your PPO effective date, we will apply any deductible met under that prior contract in the same calendar year to your PPO deductible.*

Where to Find Network Providers

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

To locate a provider in Empire's operating area, visit *www.empireblue.com.* You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Or, ask your Benefits Administrator to see Empire's PPO Directory. You can also request that a directory be mailed to you free of charge by calling Member Services at 1-800-342-9816.

Your PPO Benefits Out-of-Area

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

BlueCard® PPO Program

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

BlueCard® Program

The BlueCard Program is available whenever you travel in the United States. Simply show your Empire I.D. card, and you will benefit from discounts that participating providers have agreed to extend to their local Blue Cross and/or Blue Shield plan.

BlueCard® Worldwide

Need emergency services when traveling outside the United States? The BlueCard Worldwide program provides coverage through an international network of hospitals, doctors and other healthcare providers. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the hospital will speak English, or the program will provide translation assistance.

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

Your PPO Benefits at a Glance

Empire's PPO 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.

When you see this sign, you'll know that you or your doctor will need to precertify these services with Empire's Medical Management Program. In most cases, it is your responsibility to call. In some cases the provider or supplier of services needs to call. See the Health Management section for details.

	YOU PAY	
DOCTOR'S SERVICES (IN OFFICE)	**IN-NETWORK**	**OUT-OF-NETWORK**
OFFICE VISITS	$10 copay per visit	Deductible and 20% coinsurance
SPECIALIST VISITS	$10 copay per visit	Deductible and 20% coinsurance
CHIROPRACTIC VISITS		
• Up to an annual in-network and out of network maximum of $1,000	$10 copay per visit	Deductible and 20% coinsurance
SECOND OR THIRD SURGICAL OPINION	$10 copay per visit *	Deductible and 20% coinsurance
DIABETES EDUCATION AND MANAGEMENT	$10 copay per visit	Deductible and 20% coinsurance
ALLERGY TESTING	$10 copay per visit	Deductible and 20% coinsurance
ALLERGY TREATMENT	$0	Deductible and 20% coinsurance
DIAGNOSTIC PROCEDURES		
• X-rays and other imaging	$0	Deductible and 20% coinsurance
• MRIs/MRAs	$0	Deductible and 20% coinsurance
• All lab tests	$0	Deductible and 20% coinsurance
SURGERY	$0	Deductible and 20% coinsurance
CHEMOTHERAPY	$0	Deductible and 20% coinsurance
X-RAY, RADIUM AND RADIONUCLIDE THERAPY	$0	Deductible and 20% coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$10 copay per visit	Deductible and 20% coinsurance

** The copayment is waived if the surgical opinion is arranged through Empire's Medical Management Program.*

	YOU PAY	
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL PHYSICAL EXAM • One per calendar year	$10 copay per visit	Deductible and 20% coinsurance
DIAGNOSTIC SCREENING TESTS		
• Cholesterol: 1 every 2 years	$0	Deductible and 20% coinsurance
• Diabetes (if pregnant or considering pregnancy)	$0	Deductible and 20% coinsurance
• Colorectal cancer	$0	Deductible and 20% coinsurance
– Fecal occult blood test if age 40 or over: 1 per year		
– Sigmoidoscopy if age 40 or over: 1 every 2 years		
• Routine Prostate Specific Antigen (PSA) in asymptomatic males	$0	Deductible and 20% coinsurance
– Between ages 40-75: 1 every 2 years		
– Over age 75: 1 per year		
• Diagnostic PSA: 1 per year	$0	Deductible and 20% coinsurance
WELL-WOMAN CARE		
• Office visits	$10 copay per visit	Deductible and 20% coinsurance
• Pap smears	$0	Deductible and 20% coinsurance
• Bone Density testing and treatment	$0	Deductible and 20% coinsurance
• Mammogram (based on age and medical history)	$0	Deductible and 20% coinsurance
– Ages 35 through 39 – 1 baseline		
– Age 40 and older – 1 per year		
WELL-CHILD CARE		
• Office visits and associated lab services provided within 5 days of office visit	$0	$0
– Newborn: 1 in-hospital exam at birth		
– Birth to age 1: 7 visits		
– Ages 1 through 2: 3 visits		
– Ages 3 through 6: 4 visits		
– Ages 7 up to 19th birthday: annual visits		
• Immunizations	$0	Deductible and 20% coinsurance
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
EMERGENCY ROOM	$35 per visit copay (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	$10 copay per visit	Deductible and 20% coinsurance
AIR AMBULANCE • Transportation to nearest acute care hospital for emergency or inpatient admissions	$0	You pay the difference between the allowed amount and the total charge.
AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the allowed amount; you pay the difference between the allowed amount and the total charge.	

	YOU PAY	
MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
PRENATAL AND POSTNATAL CARE (In doctor's office)	$0	Deductible and 20% coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	Deductible and 20% coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0	Deductible and 20% coinsurance
OBSTETRICAL CARE (In hospital)	$0	Deductible and 20% coinsurance
OBSTETRICAL CARE (In birthing center)	$0	Not covered
HOSPITAL SERVICES*	**IN-NETWORK**	**OUT-OF-NETWORK*** **
ANESTHESIA AND OXYGEN	$0	Deductible and 20% coinsurance
BLOOD WORK	$0	Deductible and 20% coinsurance
CARDIAC REHABILITATION	$10 copay per outpatient visit	Deductible and 20% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	$0	Deductible and 20% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	Deductible and 20% coinsurance
DRUGS AND DRESSINGS	$0	Deductible and 20% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	Deductible and 20% coinsurance
INTENSIVE CARE	$0	Deductible and 20% coinsurance
KIDNEY DIALYSIS	$0	Deductible and 20% coinsurance
PRE-SURGICAL TESTING	$0	Deductible and 20% coinsurance
SEMI-PRIVATE ROOM AND BOARD	$0	Deductible and 20% coinsurance
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	Deductible and 20% coinsurance
SURGERY (Inpatient and Outpatient) **	$0	Deductible and 20% coinsurance

* *Does not include inpatient or outpatient behavioral health care or physical therapy/rehabilitation. Inpatient admissions and certain outpatient hospital surgeries need to be precertified.*

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

****$0 outside of the United States.*

	YOU PAY	
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK**
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	$0	Not covered
ORTHOTICS	$0	Not covered
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	$0	Not covered
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	$0	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)*	$0	Deductible and 20% coinsurance
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY • Up to 120 days per calendar year	$0	Not covered***
HOSPICE • Up to 210 days per lifetime	$0	Not covered
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
HOME HEALTH CARE • Up to 200 visits per calendar year (a visit equals 4 hours of care) †	$0	20% coinsurance***
• Home infusion therapy	$0	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICAL THERAPY AND REHABILITATION • Up to 60 days of inpatient service per calendar year†	$0	Deductible and 20% coinsurance
• Up to 60 visits combined in home, office or outpatient facility per calendar year	$10 copay per visit	Not covered
OCCUPATIONAL, SPEECH, VISION THERAPY** • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$10 copay per visit	Not covered

* *$2,500 combined in- and out-of-network limit for modified solid food products in any continuous 12-month period.*

** *Vision therapy does not require precertification.*

*** *$0 outside of the United States.*

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

	YOU PAY	
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT * • Up to 60 visits per calendar year †	$25 copay per visit	Deductible and 20% coinsurance
INPATIENT • Up to 90 days per calendar year † • Up to 90 visits from mental health care professionals per calendar year †	$0 $0	Deductible and 20% coinsurance Deductible and 20% coinsurance
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT • Up to 60 visits per calendar year, including up to 20 visits for family counseling †	$0	Deductible and 20% coinsurance
INPATIENT • Up to 7 days detoxification per calendar year † • Up to 30 days rehabilitation per calendar year †	$0 $0	Deductible and 20% coinsurance Deductible and 20% coinsurance
PHARMACY (RETAIL AND MAIL ORDER)	**IN-NETWORK**	**OUT-OF-NETWORK**
RETAIL PHARMACY	15% copayment up to a maximum of $15 per prescription	40% coinsurance (within the United States) 20% coinsurance (outside the United States)
MAIL ORDER	$10 copayment	Not covered
VISION	**IN-NETWORK**	**OUT-OF- NETWORK**
EYE EXAM • One eye exam every 24 months	$5 copay per visit	Not covered
FRAMES (limited selection)	$10 copay per pair	Not covered
LENSES (single vision, bifocal or trifocal)	$0 copay per pair	Not covered
SOFT CONTACT LENSES	$25 copay per pair	Not covered

** Out-of-network outpatient visits do not require precertification.*

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

Coverage

Doctor's Services

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

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

Tips for Visiting Your Doctor

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

Ask about a second opinion anytime that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist.

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

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

The following medical services are not covered:

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

Healthy Living Programs

Preventive Care

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

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

Tips for Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Get routine mammograms if you are a woman age 35 and over. Frequency of covered services is based on age. Women who have a family history of breast cancer will be covered for a routine mammogram as often as their physician recommends one.
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations.

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

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

- Coverage shall be available for individuals meeting the criteria of those programs, including one or more of the following:
  - Previously diagnosed with or having a family history of osteoporosis
  - Symptoms or conditions indicative of the presence or significant risk of osteoporosis
  - Prescribed drug regimen posing a significant risk of osteoporosis
  - Lifestyle factors to such a degree posing a significant risk or osteoporosis
  - Age, gender and/or other physiological characteristics that pose a significant risk for osteoporosis.

- Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. The number of visits covered per year depends on your child's age.
- Well-child care immunizations as listed:
  - DPT (diphtheria, pertussus and tetanus)
  - Polio
  - MMR (measles, mumps and rubella)
  - Varicella (chicken pox)
  - Hepatitis B Hemophilus
  - Tetanus-diphtheria
  - Pneumococcal
  - Meningococcal Tetramune
  - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

These preventive care services are not covered:

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

My Health

At Empire, our goal is to give you more control over managing you and your family's health. Visit *www.empireblue.com* to access "My Health" and receive personalized information to assist you in maintaining and improving your health. "My Health" is powered by WellMed, a leading provider of online personal health management services.

Here's some of the information you can access from "My Health":

- Assess My Health – calculate your Health IQ. This new online feature measures your health like your IQ measures your intelligence. Use it to find out how you compare to your peers and your level of risk for specific health conditions.
- Record My Health – you can safely store, manage, and maintain health information in one secure place; it's accessible anytime, anywhere.
- Improve My Health – this interactive health improvement program can help you manage your health concerns such as smoking cessation, fitness and nutrition and pregnancy planning.

Plus, get information about health concerns from A - Z.

Health A – Z is a new feature from My Health that provides fast access to important information on over 150 health topics, such as back and neck pain, cold and flu and anxiety. Just click on any topic and get answers to questions about you and your family's health.

Visit *www.empireblue.com* and register or log on to Online Member Services. From your member home page, click on "My Health". This will take you to your own personalized health page with interactive features that will enable you to measure and manage your health every day.

For more information or assistance, call Member Services at 1-800-342-9816.

If you become ill and feel that you need urgent or after hours care, call your provider. Or, call Empire HealthLine toll-free, 24 hours a day, seven days a week, at 1-877-TALK2RN, (825-5276) for advice from registered nurses.

Healthy Discounts@Empire

Empire members qualify for exclusive discounts on the following additional health and nutritional services through our Healthy *Discounts@Empire* Program.

Vision Care

Save on laser vision correction, as well as general eye care, including complete eye exams, lenses, frames, and mail order contact lens replacement*.

Wellness Products

Members receive preferred pricing on thousands of quality health and wellness products, including vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products and more*.

Alternative Practitioners

Members receive discounts on massage and chiropractic therapy, nutritional counseling and acupuncture through participating alternative practitioners*.

Save Money on Health Club Membership

Show your Empire I.D. card to **receive the lowest rates** currently offered for the type of membership you select **at hundreds of health clubs** nationwide participating in the International Fitness Club Network (IFCN)*.

Guest Membership Certificates entitle you and all immediate family members to **one free week** at the network club of your choice. To get your certificate, log on to the IFCN Web site at: *www.ifcn.org*

- Click on “Member’s Area”
- Click on “Free Certificates”
- Enter “emp” for the first three letters of insurer’s name.

For more information, call 1-800-866-8466 (account code 3500).

**Through arrangements with American Specialty Health Networks, Davis Vision and the International Fitness Club Network, members are entitled to discounts on services rendered by participating providers and practitioners. Discounted vision services are available only to Empire members who are not covered by a Davis Vision care benefits rider to their health insurance plan. If you are covered by a Davis Vision care benefits rider, then many of these discounts are actively covered benefits under your plan. Call the number on the back of your ID card to verify your vision coverage.*

These services and products may not be available to all groups and in all states and are not covered benefits under your Empire healthcare plan. We make no payment for these value-added programs available to you.

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

Save Money While Losing Weight With **Weight Watchers**®[1]

Show your Empire I.D. card to receive **free registration at Weight Watchers** programs in New York (except Suffolk county), New Jersey (Hudson and Bergen counties) and Connecticut. For more information, call 1-800-651-6000 or visit *www.weightwatchers.com*

For more information about these services, including information about practitioners, visit *www.empireblue.com* under *About Empire*. Or call Member Services at 1-800-342-9816.

Asthma Management Program

Even the most severe asthmatics can live an active life by learning how to control or prevent an asthma episode. Empire's Asthma Management Program, is designed to identify and assist asthmatic members to effectively control their asthma.

This program is managed by a team of certified nurse case managers whose primary goal is to assist members in:

- Understanding asthma and its symptoms
- Controlling the environment triggers
- Self monitoring skills
- Risk factor modification
- Creating an action plan to control their asthma.

If you need information on controlling your asthma, call the Asthma Management Program Help Line at 1-800-864-6860. Registered nurses are available 24 hours a day, seven days a week to answer your questions.

Visit *www.empireblue.com* and register or login to Online Member Services. From your member homepage, click on "My Health." This will take you to your own personalized health page with interactive features that will enable you to measure and manage your health every day.

If you or any of your eligible dependents do not want to participate in the Asthma Management Program, notify Empire in writing at the following address:

Empire Asthma Management
Empire BlueCross BlueShield
P.O. Box 3560
Church Street Station
New York, NY 10008-3560

Please include your Empire ID number, the names and dates of birth of you and your eligible dependents.

Emergency Care

If You Need Emergency Care

Should you need emergency care, your PPO is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs or parts
- Cause serious disfigurement
- In the case of behavioral health, place others or oneself in serious jeopardy

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

Emergency Assistance 911

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

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

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

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

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

Tips for Getting Emergency Care

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

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

Air Ambulance

Air ambulance is provided to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care when the following conditions are met:

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

If Empire determines that the condition for coverage for air ambulance services has not been met, but your condition did require transportation by land ambulance to the nearest acute care hospital, Empire will only pay up to the amount that would be paid for land ambulance to that hospital.

Remember to call Empire's Medical Management Program at 1-800-982-8089 to receive benefits for air ambulance.

Maternity Care

If You Are Having a Baby

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

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

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

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

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

Empire BabyCare℠ Program

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

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

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

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

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

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 obstetrician/gynecologist to receive the lowest cost maternity care.

Hospital Services

If You Visit the Hospital

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

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

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

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

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

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

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

Tips for Getting Hospital Care

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

Inpatient and Outpatient Hospital Care

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

- Diagnostic x-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration)
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs when pre-approved by Empire's Medical Management Program

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 Empire's Medical Management Program review, unless otherwise specified

- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

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

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

Outpatient Hospital Care

Following are additional covered services for same-day care:

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

Inpatient Hospital Care

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

Outpatient Hospital Care

These outpatient services are not covered:

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

Durable Medical Equipment and Supplies

If You Need Equipment or Medical Supplies

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

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

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

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

Tip for Obtaining Special Medical Supplies

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

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

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor and approved by Empire's Medical Management Program, including:
  - Artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
  - Prescription lenses, if organic lens is lacking
  - Supportive devices essential to the use of an artificial limb
  - Corrective braces
  - Wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
- Rental (or purchase when more economical) of medically necessary durable medical equipment
- Replacement of covered medical equipment because of wear, damage or change in patient's need, when ordered by a physician
- Reasonable cost of repairs and maintenance for covered medical equipment

- Enteral formulas with a written order from a physician or other licensed health care provider. The order must state that:
  - The formula is medically necessary and effective, and
  - Without the formula, the patient would become malnourished, suffer from serious physical disorders or die.
- Modified solid food products for the treatment of certain inherited diseases. A physician or other licensed healthcare provider must provide a written order.

The following equipment is not covered:

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

Skilled Nursing and Hospice Care

If You Need Skilled Nursing or Hospice Care

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

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

Skilled Nursing Care

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

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

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

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

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

Tips for Receiving Skilled Nursing and Hospice Care

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

Home Health Care

If You Need Home Health Care

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

Remember, in order to receive maximum benefits, you need to precertify home health care through Empire's Medical Management Program. If you use a home health care agency in the Empire network, the agency is responsible for calling Medical Management. If you use a home health care agency in the BlueCard PPO network or out-of-network, *you* need to call Medical Management. (The agency can call for you; however, you need to ensure that they call.)

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. If you use an Empire network home infusion supplier, the supplier must call Medical Management for precertification. While a BlueCard PPO supplier can call to precertify your treatment, you need to ensure that they call.

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

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

- Up to 200 precertified home health care visits per year, combined in- and out-of-network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests

The following home health care services are not covered:

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

Physical, Occupational, Speech or Vision Therapy

If You Need Therapy

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

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

Tip for Receiving Therapy

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

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

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

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

The following therapy services are not covered:

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

New Medical Technology

Requesting Coverage

Empire uses a committee composed of Empire Medical Directors, who are doctors, and participating network physicians to continuously evaluate new medical technology that has not yet been designated as a covered service. If you want to request certification of a new medical technology before beginning treatment, your provider must contact Empire's Medical Management Program. The provider will be asked to do the following:

- Provide full supporting documentation about the new medical technology
- Explain how standard medical treatment has been ineffective or would be medically inappropriate
- Send us scientific peer reviewed literature that supports the effectiveness of this particular technology. The literature must not be in the form of an abstract or individual case study.

Empire's staff will evaluate the proposal in light of your contract and Empire's current medical policy. Empire will then review the proposal, taking into account relevant medical literature, including current peer review articles and reviews. Empire may use outside consultants, if necessary. If the request is complicated, Empire may refer your proposal to a multi-specialty team of physicians or to a national ombudsman program designed to review such proposals. Empire will send all decisions to the member and/or provider.

Behavioral Health Care

If You Need Behavioral Health Care

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

Please note that, with the exception of outpatient alcohol and substance abuse treatment, the coinsurance that you pay for out-of-network behavioral health care services will not count toward reaching your annual out-of-pocket maximum.

To help ensure that you receive appropriate care, you need to precertify all behavioral health care services in advance, except for outpatient mental health care on an out-of-network basis. When you call the Behavioral Health Care Management Program at 1-800-626-3643 to precertify in-network services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

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

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

When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Health Care Management Program at 1-800-626-3643 within 48 hours or as soon as is reasonably possible.

If you want to know if a provider or facility is covered in-network, call the Behavioral Health Care Management Program.

If you do not agree with a certification decision made by the Behavioral Health Care Management Program, you can file an appeal. For more information see "Appeals and Grievances" in the Details and Definitions section.

Mental Health Care

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

- Care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders
- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Health Care Management

The following mental health care services are not covered:

- Out-of-network inpatient mental health care at a facility that is not an acute care general hospital

Treatment for Alcohol or Substance Abuse

In addition to the services listed in Your PPO Benefits at a Glance section, the following services are covered:

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive one counseling visit per day.
  - Visits for family counseling are deducted from the 60 visits available for outpatient treatment.
- Out-of-network outpatient treatment at a facility that:
  - Has New York State certification from the Office of Alcoholism and Substance Abuse Services
  - Is approved by the Joint Commission on the Accreditation of Health Care Organizations if out of state. The program must offer services appropriate to the patient's diagnosis.

The following alcohol and substance abuse treatment services are not covered:

- Out-of-network outpatient alcohol or substance abuse treatment at a facility that does not meet Empire's certification requirements as stated above
- Care that is not medically necessary
- Out-of-network inpatient alcohol or substance abuse rehabilitation at a facility that is not an acute care general hospital
- Out-of-network inpatient detoxification at a facility that is not an acute care general hospital

Empire Pharmacy Management℠

Your Pharmacy Benefits Program

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

Prior Authorization

Certain drugs require prior authorization. They are identified as "PAR" (Prior Authorization Required) and must be approved by Empire before you fill the prescription. To find out which drugs require prior authorization, visit Empire's website at *www.empireblue.com*, or call Empire Pharmacy Management. Your physician or pharmacist can request this authorization by calling Empire Pharmacy Management at 1-800-342-9816. If the drug is approved, it will be covered.

Network Pharmacy

The advantages of using a network pharmacy are:

- Low cost. A network pharmacy will charge you a 15% copayment, up to a maximum of $15 for each prescribed drug.
- Convenience. Just present your Empire I.D. card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program. You can receive up to a 34-day supply for each prescribed drug and up to 100 unit doses for certain maintenance medications.
- No claim forms. The pharmacist submits your claim when you fill the prescription.

Non-Network Pharmacy

If you receive drugs from any pharmacy other than a network pharmacy, you must pay the pharmacy in full and submit a claim form with the pharmacy bill for reimbursement. You will then be responsible for a 40% coinsurance of the billed charges for pharmacies within the United States, 20% if the pharmacy is outside the United States.

Prescriptions filled at an out-of-network pharmacy must be paid in full. You may then submit a claim for reimbursement.

Generic and Brand Name Drugs

New York State law requires that pharmacists dispense approved generic equivalents instead of brand name drugs when your doctor does not indicate Dispense As Written (DAW) on the prescription.

- If you request a brand name drug, when a generic drug is available and your doctor did not specify "DAW", you must pay the *ancillary charge* (the price difference between the generic drug's allowed amount and the brand name drug's price).
- If there is no generic equivalent for a brand name drug, the generic drug copayment will apply.

Tip for Using a Network Pharmacy

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

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

Mail Order

You may also choose to use the mail order feature of this program. It is ideal for members who use prescription drugs to treat a chronic health condition, such as high blood pressure or diabetes. You can obtain a one year prescription from your physician, then order up to a 90-day supply of medication at a time through the mail order program. For each 90-day supply, you pay a $10 copay for generic and brand name drugs.

How to Use the Mail Order Program

- Ask your physician for a written prescription.
- Use the form sent with your I.D. card or request a form by calling Empire Pharmacy Management at 1-800-342-9816.
- Send each new order to the address on the order form.
- You will receive your filled prescription at home within 14 days, postage-paid.
- Mail order refills can be requested online by logging onto *www.empireblue.com* and clicking on the Rx icon on your homepage.

Tips for Using Mail Order

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

Manage Your Pharmacy Plan Online

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

- Search Empire's drug formulary for a particular drug (by name or therapeutic category)
- Locate a participating retail pharmacy near where you live or work
- Order prescription refills through the mail order program
- Research usage instructions, drug interactions and side effects for thousands of medications

Simply log on to our web site and access your own personal secure home page. Click on "My Pharmacy Plan" which is right next to the Rx symbol under "Your Health Plan." You'll immediately be connected to AdvanceRx.com. It's like having a pharmacy right in your own home.

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

If you have an urgent eligibility question after normal business hours, the Empire HealthLine can verify your enrollment status.

The following prescription drugs are covered:

- Insulin and self-administered injectables
- Diabetic supplies and equipment
- Nutritional supplements for metabolic disorders, when medically necessary and proven effective for treatment
- Infertility drugs
- Oral contraceptives
- Smoking cessation products that require a prescription are covered up to three 30-day supplies per lifetime
- Refills for up to one year from the date of the original prescription, if authorized by the physician and indicated on the prescription

The following items are not covered:

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

Vision Care

If You Need Vision Care

Empire recognizes that good vision is part of good health, so we offer vision care coverage. You receive vision care benefits only when you use network providers. There are no out-of-network benefits for vision care. To find a participating provider in your area, simply call 888-EYEBLUE (393-2583) between 8:00 a.m. and 8:00 p.m. weekdays, 9:00 a.m. and 4:00 p.m. Saturdays. Then contact the provider to make an appointment. Benefits are paid in full when you use a network provider, subject to the copayments shown below.

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

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

You can use different providers for eye examinations and eyewear, and you do not have to purchase the eyewear at the same time as your examination.

Vision care benefits include one comprehensive eye exam, and a select group of eyewear (frames with corrective lenses or contact lenses) every 24 months for each covered member. Eye exams must be conducted in a single visit.

The following vision care services are not covered:

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

Exclusions and Limitations

Exclusions

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

Dental Services

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

However, your plan does cover:

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

Experimental/Investigational Treatments

- Technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are:
  - Experimental or investigative
  - Obsolete or ineffective
- Any hospitalization in connection with experimental or investigational treatments.

"Experimental" or "investigative" means that for the particular diagnosis or treatment of the covered person's condition, the treatment is:

- Not of proven benefit
- Not generally recognized by the medical community (as reflected in published medical literature)

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

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

However, your plan will cover an experimental or investigational treatment approved by an External Appeal agent certified by the state.

Government Services

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

Medically Unnecessary Services

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

Miscellaneous

- Surgery and/or treatment for gender change

Prescription Drugs

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

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

War

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

Workers' Compensation

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

Limitation as Independent Contractor

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

Health Management

Helping You Manage Your Health

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 three important services: Medical Management, Case Management and Empire HealthLine[SM].

Empire's Medical Management Program

Empire's Medical Management Program is a service that precertifies hospital admissions and certain treatments and procedures to ensure that you receive high quality care for the right length of time, in the right setting, with maximum coverage.

When you call Empire's Medical Management Program, you reach a team of professionals who know how to help you manage your benefits to your best advantage. They can help you to:

- Learn more about your healthcare options
- Choose the most appropriate healthcare setting or service (e.g., hospital or same-day surgery unit)
- Avoid unnecessary hospitalization and the associated risks, whenever possible
- Arrange for any required (and covered) discharge services

To help ensure that you receive quality care, Empire's Medical Management Program works with you and your provider to:

- Review planned and emergency hospital admissions
- Review ongoing hospitalization
- Coordinate purchase and replacement of durable medical equipment, prosthetics and orthotics
- Review inpatient and same-day surgery
- Review high risk pregnancies
- Perform individual case management
- Review care in a hospice or skilled nursing facility
- Review home health care and home infusion therapy
- Coordinate discharge planning

In most situations, you or someone acting on your behalf needs to call the Medical Management Program to precertify hospital admissions and certain services. In other cases, the vendor or provider of services needs to call. This will ensure you receive maximum benefits.

The following chart shows which healthcare services must be precertified with Empire's Medical Management Program before you receive them.

CALL TO PRECERTIFY...	HOW COVERED	WHO CALLS TO PRECERTIFY
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 • For illness or injury to newborns	In-network and Out-of-network	YOU
PREGNANCY • Within the first three months of a pregnancy		
BEFORE YOU RECEIVE • Inpatient physical therapy • Same-day surgery for medically necessary cosmetic/reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures • Cardiac rehabilitation • A magnetic resonance imaging or magnetic resonance angiography scan (MRI or MRA)		
BEFORE YOU RECEIVE • Hospice care • Occupational or speech therapy • Outpatient physical therapy • Skilled nursing facility care • Air ambulance service	In-network only	YOU
BEFORE YOU RECEIVE • Home health care services	Empire network	NETWORK SUPPLIER
	Out-of-network or BlueCard PPO network	YOU
BEFORE YOU • Receive home infusion therapy • Rent, purchase or replace prosthetics, orthotics or durable medical equipment	Empire network	NETWORK SUPPLIER
	BlueCard PPO network	YOU

When you call the Medical Management Program to precertify services, you receive maximum benefits and helpful advice about your options.

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 $2,500 for each admission, treatment or procedure. 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.

Tips for Precertifying Services with Medical Management

- Have the following information about the patient ready when you call:
  - Name, birth date and sex
  - Address and telephone number
  - Empire I.D. card number
  - Name and address of the hospital/facility
  - Name and telephone number of the admitting doctor
  - Reason for admission and nature of the services to be performed
- When the vendor or provider is required to call Empire's Medical Management Program for precertification, be sure they know about the precertification requirement and that they have the Medical Management telephone number.

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 you must contact Empire's Medical Management Program for approval before you receive certain health care services. We will review all requests for precertification within three (3) business days of receipt of the 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 three (3) business days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within three (3) business days of our receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.
- *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, of if no response is received, within 48 hours after the deadline for a response.

- *Concurrent Requests.* Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care. 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, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within 15 calendar days of our receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

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

If a Request Is Denied

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

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

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. Empire 's nurses can help you and your family:

- Find appropriate, cost-effective healthcare options
- Reduce medical costs
- Assure quality medical care

A Case Manager serves as a single source for patient, provider, and insurer – assuring 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, Empire's 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 PPO is desirable, appropriate and cost-effective. If you would like Case Management assistance following an illness or surgery, contact Empire's Medical Management Program at 1-800-982-8089.

Empire HealthLine[SM]

Need Health Information or Advice?

At Empire, we understand that part of maintaining your health is having the information you need to make informed decisions, so we have the people and programs in place to help. Questions about your healthcare? Call Empire HealthLine, a round-the-clock information line available free of charge to Empire members. When you call in you will have the option to either speak to a registered nurse or listen to over 1,100 audiotape messages on a wide variety of topics. If you don't speak English, interpreters are also available through the AT&T Language Line.

When You Should Call

Below are some examples of situations you may find yourself in when the HealthLine can be of assistance to you and your family. This list is by no means complete, so if you ever find yourself in need of any health advice, call us. The nurses at the HealthLine are here to help you.

Assessing Symptoms

- Child has a fever of 103 and you are not sure what to do
- Can't tell if you've sprained or broken your ankle
- Cut your hand on a piece of glass and are not sure if a trip to the emergency room is necessary
- On vacation and don't know where to go for help with a medical problem
- Don't know the cause of the rash on your arm
- Been feeling sad for weeks and wonder what you should do

Understanding a Medical Condition, Procedure, Prescription, or Diagnosis

- Need information about a personal health issue such as diet, exercise or high blood pressure
- Scheduled a cholesterol test but don't fully understand the results
- Not sure about the possible side effects of certain medications
- Have a question about pregnancy
- Want to know about the signs and symptoms of sexually transmitted diseases

Discharge from a Hospital

- Doctor says you need a wheelchair delivered to your home in order to be discharged from the hospital and you need help finding one
- Doctor has sent you home with a discharge treatment plan you do not fully understand

Audio Health Library

- Information about specific health conditions and procedures
- More than 1,100 healthcare topics available in English and Spanish. Refer to the directory at the back of your booklet for a listing of available topics.

Dialing In

- Dial 1-877-TALK-2RN (825-5276) and follow the prompts to speak with a nurse or to listen to the audio messages.
- If you plan on listening to the tapes, have your member number handy. You will need to enter the first three digits. For example, if your number is YLD123456789, enter YLD (953).
- The appendix contains a complete listing of audio message topics. Note the code number to the right of the topics that you want to listen to, as you will be prompted for these numbers.
- If you have additional questions after listening to a tape, simply connect to the on-duty nurse.

The Wrong Time to Call

Empire HealthLine is NOT for life-threatening emergencies, so please DO NOT call if you believe you or a family member

- is having a heart attack or stroke
- is severely injured
- is unable to breathe
- may have ingested poisonous or toxic substances
- is unconscious

IN THESE CASES, CALL 911 or your local Emergency Service as soon as possible!

Empire HealthLine℠
1-877-TALK-2RN (825-5276)
24 hours a day, 365 days a year

Details and Definitions

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

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

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

Eligibility

Eligibility

The eligibility rules and administrative procedures for adding and removing dependents for your coverage are sent out in an annually distributed official issuance of the United Nations. Please do not contact Empire regarding enrollment or eligibility questions.

Claims

If You Need to File a Claim

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

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

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

Send completed forms to:

Hospital Claims

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

Medical Claims

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

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

Tips for Filing a Claim

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

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

If You Have Medical Coverage Under Two Plans
(Coordination of Benefits – COB)

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

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

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

Which Plan Pays Benefits First?

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

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.

  - If the parent with custody is remarried, his or her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire Is the Secondary Plan

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

Tips for Coordinating Benefits

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

If You Receive An Overpayment Of Benefits

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

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

Health Care Fraud

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

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

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

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

Complaints, Appeals and Grievances

Quality Assurance

Quality healthcare is important to you and Empire. In the event that you are less than satisfied with a benefit payment, a coverage decision, or with one of our network providers, there are steps you can take to resolve your concerns.

When you have questions or concerns, you should call Member Services at 1-800-342-9816. In most cases, Member Services will be able to answer your questions. If you are not satisfied, you may file a complaint, grievance or appeal with Empire by phone or by writing to us at:

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

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

Empire BlueCross BlueShield
P.O. Box 5110
Grand Central Station
New York, NY 10163-5110
Attention: Behavioral Healthcare Program

Your Right to Appoint a Representative

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

Provider Quality Assurance

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

If you have a complaint about a network provider's procedures or treatment decisions, share your concerns directly with your provider. If you are still not satisfied, you can submit a complaint to Member Services. 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 policy and procedures. If you have any recommendations on improving our policies and procedures, please send them to the Member Services address on the previous page.

Complaints

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

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.

You may also call the New York State Department of Health Complaint Hotline at any time, for any reason at 1-800-206-8125.

Office of Managed Care
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Standard Internal Appeals

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

Appeals may be filed by telephone or in writing.

Level 1 Appeals

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

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

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

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

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

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

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal. If Empire's Medical Management Program does not make a decision within calendar 60 days of receiving all necessary information to review your appeal, Empire will approve the service.

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

Expedited Level 1 Appeals

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

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

Expedited Appeals may be filed by telephone and in writing.

- You or your provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request.
- Empire will make a decision within two business days of receipt of all necessary information but in any event within 72 hours of receipt of the appeal.
- Empire will notify you immediately of the decision by telephone, and within 24 hours in writing.

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you have exhausted all internal appeal options. If Empire's Medical Management Program does not make a decision within 2 business days of receiving all necessary information to review you're a ppeal, Empire will approve the service.

Level 2 Appeals and Timeframes

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

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

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

Level 1 Grievances

A grievance is a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity. For example, a claim was denied because the member did not obtain precertification for services.

A Level 1 Grievance is your first request for review of Empire's administrative decision. You have 180 calendar days from the receipt of the notification letter to file a grievance. A grievance submitted beyond the 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 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance. A qualified representative (including clinical personnel, where appropriate) who did not participate in the original decision will review your grievance and a description of any additional information required to complete the review.

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

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

Decision on Grievances

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

- The reason for Empire's decision
- 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

Level 2 Grievances

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

We will make a decision within the following time frames for 2nd Level Grievance:

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

Expedited Grievances

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

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

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

How to File an Appeal or Grievance

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

The address for filing an appeal or grievance is:

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

Ending and Continuing Coverage

When Coverage Ends

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

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

Continuing Coverage Under New York State Law

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

Converting Your Coverage

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

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

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

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

To convert your coverage, you must:

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

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

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

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

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

Ending and Continuing Coverage

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

Portability of Coverage

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

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

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

If You Become Disabled

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

Coverage will end when the disabled person:

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

Your Rights as a PPO Member

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

Access to Information

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

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

For Members Who Don't Speak English

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

Confidentiality Policy

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

- Empire has in place and enforces appropriate safeguards to protect the confidentiality, security and integrity of member medical information.
- Confidential member medical information is accessible only to those Empire employees and authorized third persons who need it to perform their jobs. All persons are required to comply with Empire policies and procedures and federal and state laws and regulation concerning the use, disclosure, release, security, storage and destruction of confidential member medical information.

- When you become covered under your Empire health benefit plan, you agree that Empire, or its designee, may use and/or disclose your confidential medical information for purposes of payment and healthcare operations as permitted or required by law or regulation. In addition, each Empire member agrees that any healthcare provider, healthcare payor or government agency shall furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made for use and/or disclosure by Empire to administer the terms of the health benefit plan.
- Disclosure of confidential information to external vendors for purposes of payment or health care operations is made only in accordance with appropriate confidentiality agreements and contractual arrangements. Data shared with external entities for measurement purposes or research is released only in accordance with appropriate confidentiality agreements and contractual arrangements or in an aggregate form that does not allow for direct or indirect member identification.
- Identifiable personal health information is not shared with your employer, unless permitted or required by law. Because Empire is not a provider of medical services, it generally does not maintain medical records created by your provider of service. If you require access to your provider's medical records, please contact your provider to arrange access.
- Empire requires all of its network practitioners and providers to ensure the privacy and to protect the confidentiality of members' medical information.
- You may request access to any other information that is maintained by or for Empire by calling Member Services to arrange access.
- Except as stated above and as may be permitted or required by law, Empire does not release confidential member medical information to anyone outside Empire without a specific "written authorization" to release, authorized by the member or member's designee, which may be revoked at any time. The authorization must specify:
  - The information that can be disclosed
  - What the information will be used for, and
  - The time period for which the authorization applies.

HIPAA Privacy Requirements

Employer/Sponsor

1.

Under the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations (45 C.F.R. Parts 160-64), referred to as HIPAA, the Employer/Sponsor of a Group Health Plan (the "Plan") may obtain and use a member's summary information[1] for purposes of obtaining premium bids, to modify, amend or terminate the Plan, and for enrollment and eligibility determinations.

Under the requirements of HIPAA, the Employer/Sponsor may obtain and use a members' Protected Health Information[2] (PHI) for purposes of Plan administration. To the extent the Employer/Sponsor requires PHI. Prior to receiving PHI, the Employer/Sponsor shall certify to the Plan that the Plan Document/Benefit Booklet meets the requirements of HIPAA (as described below). (Remove redline if group is ASO)

Employer/Sponsor Obligations

2.

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

Purpose of Disclosure to Employer/Sponsor

(a) The Plan and any health insurer or HMO will disclose members' PHI to the Employer/Sponsor only to permit the Employer/Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Employer/Sponsor of members' PHI will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.

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

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

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

2. Health information that is created or received by a health plan, insurer or HMO that relates to an individual's physical or mental health or condition, including information related to an individual's care or the payment for such care.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

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

(b) The Employer/Sponsor will ensure that any agent, including any subcontractor, to whom it provides members' PHI, agrees to these restrictions and conditions in the Plan Document/Benefit Booklet, with respect to members' PHI.

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

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

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

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

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

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

(i) The Employer/Sponsor will, if feasible, return or destroy all member PHI, in whatever form or medium (including in any electronic medium under the Employer's/Sponsor's custody or control), received from the Plan that the Employer/Sponsor still maintains, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the members' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all members' PHI, the Employer/Sponsor will limit the use or disclosure of any member PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation between the Employer/Sponsor and the Plan

4.

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

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

(2) The employees, classes of employees or other workforce members identified in paragraph 3(a) above will have access to members' PHI only to perform the Plan administration functions that the Employer/Sponsor provides for the Plan.

(b) The employees, classes of employees or other workforce members identified in paragraph 3(a) above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer/Sponsor, for any use or disclosure of members' PHI in breach or violation of or noncompliance with these provisions of the Plan Document/Benefit Booklet. The Employer/Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 2(d) above, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

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's Medical Management that reduces or denies benefits.

Allowed Amount

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

Ambulatory Surgery

See "same-day surgery."

Annual Out-of-Pocket Coinsurance Maximum

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

Authorized Services

See "precertified services."

BlueCard® Program

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

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

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

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

The negotiated price may reflect:

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

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

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

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

BlueCard® Worldwide Program

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

- Call 1-800-810-BLUE (2583), 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as copayments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.

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

Coinsurance

When you get care out-of-network, you and your PPO share the cost of covered expenses, after you meet the deductible. For example, if your PPO pays 80% of the allowed amount, you pay 20% plus any costs above the allowed amount. Once your coinsurance expenses reach the annual out-of-pocket maximum, your PPO will pay 100% of the provider's charge or the allowed amount, whichever is less.

Copayment

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

Covered Services

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

Deductible

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

Hospital/Facility

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

Hospital/Facility

- Assigned emergency personnel and a "crash cart" to treat cardiac arrest and other medical emergencies
- Diagnostic radiology facilities
- A pathology laboratory
- An organized medical staff of licensed doctors

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

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

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

For behavioral 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 alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Healthcare Organizations.

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

Empire's PPO 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 providers and suppliers. Services provided must fall within the scope of their individual professional licenses.

In-Network Provider/Supplier

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

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

Itemized Bill

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

Lifetime Maximum

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

Medically Necessary

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

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

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

Non-Participating Hospital/Facility

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

Operating Area

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

Out-of-Network Benefits

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

Out-of-Network Providers/Suppliers

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

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

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that:

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

Plan Administrator

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

Precertified Services

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

Provider

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

For behavioral health care purposes, "provider" includes care from psychiatrists, psychologists or certified social workers (with three or more years of post-degree supervised experience), providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

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

Same-Day Surgery

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

Treatment Maximums

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

HealthLine Audiotape Topics

Following is a list of some of our most popular health-related audiotape topics that you can listen to free of charge, 24 hours a day, seven days a week, when you call Empire HealthLine at 1-877-TALK-2RN (825-5276). See the Health Management section for more information on Empire HealthLine and instructions on how to listen to the tapes. These are our most requested audiotapes; there are more than 1,100 available. If you do not see the topic that interests you just ask one of the HealthLine nurses.

Aging

7805 Alzheimer's Disease
7845 Impotence in Older Men
7878 Sleep Problems

Alcohol Problems

4131 Alcoholism – Causes
4133 Alcoholism - The Disease of Denial

Arthritis

4172 Arthritis Or Rheumatism?
4171 Arthritis Symptoms
4175 Osteoarthritis

Back and Neck

4192 Back Pain – Causes
4193 Exercises for the Desk Bound
4199 Neck Pain

Blood and Circulatory

4211 Anemia
6104 Aneurysms

Bones, Joints and Muscles

4239 Gout

Cancer

6417 Colon Cancer
6429 Leukemia – Chronic
6481 Pancreatic Cancer
6453 Seven Warning Signs of Cancer
6459 Stomach Cancer
6465 Throat Cancer
6486 Thyroid Cancer

Cardiovascular Health

6101 Abnormal Heartbeat
6113 Chest Pain (Other Than Angina)
6116 Cholesterol - "Good" and "Bad"
6119 Congestive Heart Failure

Cardiovascular Health (cont.)

6129 Early Warning of Heart Attack
6144 High Blood Pressure And Heart Disease
6170 Triglycerides

Common Illnesses

4332 Eczema

Digestive System

5400 Anal Fissure and Fistulas
4411 Colitis
4412 Constipation in the Digestive System
5402 Crohn's Disease
4413 Diarrhea in the Digestive System
4422 Diverticulosis and Diverticulitis
5404 Gallbladder Disease
5406 Gastroenteritis
4415 Heartburn and the Digestive System
4416 Hemorrhoids
5411 Intestinal Gas
4419 Irritable Bowel Syndrome
5414 Pancreatitis
5416 Rectal Bleeding
4421 Ulcers – Overview

Ear, Nose and Throat

4453 Ear Wax (Cerumen)
4456 Ringing in the Ear - Causes
4457 Sinus Problems

Eyes and Vision

4512 Double Vision
4513 Eye Symptoms Demanding Immediate Attention
4517 Spots and Floaters

Hormonal Disorders

4701 Hyperthyroidism (Overactive Thyroid)
4702 Hypothyroidism (Underactive Thyroid)

Infectious Diseases

4735 Fifth Disease
4724 Lyme Disease

Men's Health

4764 Prostate Problems

Mental and Emotional Health

6707 Anxiety
6717 Depression and its Symptoms
6720 Exhibitionism
6725 Grief and Loss
6733 Kleptomania
6735 Letting Go of Resentment
6737 Manic or Bipolar Depression
6744 Narcissism
6745 Nervous Breakdown
6748 Obsession and Compulsion
6749 Panic Attacks
6763 Schizophrenia
6773 Suicide
6777 Voyeurism

Respiratory Problems

4933 Chronic Cough - A Significant Respiratory Problem
4934 Emphysema

Sexually Transmitted Diseases

4951 Chlamydia
4953 Herpes
4955 Syphilis

Skin Health

4975 Psoriasis

Sports Medicine

7462 Tendonitis

Stress and How to Cope

5131 10 Stress Busters You Can Do
5132 Burnout - Is It Happening to You?
5133 Facing Financial Troubles
5134 How Friends Buffer Stress
5135 Mental Exercises For Stress Management
5138 Stress – What Is It?

Symptoms

6127 Dizziness as a Symptom

Teenage Concerns

5227 Homosexuality
5228 Masturbation
5226 Think You're Gay?

Tests and Examinations

6418 Colonoscopy
6131 Echocardiography
5241 Endoscopic Retrograde Cholangiopancreatography (ERCP)
7465 Thyroid Tests

Urinary and Genital Systems

5261 Bladder Stones
5262 Blood in Urine
5267 Women and Urinary Infections

Weight Control

6911 Choosing a Commercial Diet Program
6981 Teaching Your Body to Burn More Calories

Women's Health

7134 Hot Flashes
7135 Hysterectomy
7144 Menopause Problems?
5313 Sexual Response in Women
7191 Yeast Infections

Other Categories:

Allergies
Brain and Nervous System
Child Health and Development
Cosmetic and Reconstructive Surgery
Dental Health
Diabetes
Drug Abuse
Eating Disorders
Exercise and Fitness
Family Planning
Foot Care
General Health
Genetic Disorders and Birth Defects
Headaches
Health Quizzes
Hearing
HIV Infection/AIDS
Medications
Neurology
Newborn Care
Nutrition
Parenting and Family Life
Personal Safety
Pregnancy and Childbirth
Preparing for Emergencies
Surgery