United Nations
Group 374610- A, D, G, I, M1, M2, M3, M4, M5, M6, M7, M8

PPO

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1/2021

Effective Date 7/1/2020

Welcome!

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

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

YOUR PPO – A SMART WAY TO GET HEALTHCARE

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

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

WHAT'S THE EMPIRE PPO ADVANTAGE?

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

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

HOW TO USE THIS GUIDE

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

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

IF YOU ARE LOOKING FOR …	YOU'LL FIND IT IN	ON PAGE
• HOW THE PLAN WORKS	USING YOUR PPO	6
• WHAT'S COVERED	COVERAGE	17
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	41
• HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	50

[*] *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.*

Our Role in Notifying You

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

Conformity with Law

Any term of this Booklet which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

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

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

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

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

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

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

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Introduction

Getting Answers Your Way

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

ON THE INTERNET

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

BY TELEPHONE

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	1-855-519-9537 TDD for hearing impaired: **1-800-682-8786** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** *www.bcbs.com* 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures.	1-855-519-9537 8:30 a.m. to 5:00 p.m. Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
EMPIRE'S PHARMACY PROGRAM	Information about the program Locate a participating retail pharmacy Obtain a complete drug formulary list	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 7:00 a.m. to 10:00 p.m. Monday –- Friday 9:00 a.m. to 9:00 p.m. Saturday 9:00 a.m. to 5:30 p.m. Sunday
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

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 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 network of Blue Cross and Blue Shield plans through the BlueCard® PPO Program.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a co-payment OR /deductible and coinsurance payment for office visits and many other services.
- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- CONVENIENCE – Usually, there are no claim forms to file.
- Out-of-network services are healthcare services provided by a licensed provider outside Empire's PPO network or the BlueCard PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:
  - You pay an annual deductible and coinsurance, plus any amount above the maximum allowed amount (the maximum Empire will pay for a covered service) This amount is currently 275% of Medicare's Fee Schedule (except for physical therapy services, which is 200% of Medicare's Fee Schedule and Certified Social Worker, which is 225% of Medicare's Fee Schedule); if you use a BlueCard provider you will pay only the lower of billed charges or a negotiated rate and your member liability
  - You will usually have to pay the provider when you receive care
  - You will need to file a claim to be reimbursed by Empire

The following chart shows your specific plan information as of July 1, 2013.
See the Details and Definitions section for explanations of terms in the chart.

	IN-NETWORK	OUT-Of-NETWORK
ANNUAL DEDUCTIBLE	$0	$250/Individual $750/Family
CO-PAYMENT (for office visits and certain covered services)	$15 per visit (Non-Specialist) $20 per visit (Specialist)	N/A
CO-PAYMENT (for hospital inpatient admissions)	$0	N/A
CO-PAYMENT (for emergency room)	$75 per visit (waived if admitted to hospital within 24 hours)	$75 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	N/A	You pay 20% of allowed amount. Plan pays 80% of maximum allowed amount
ANNUAL OUT-OF-POCKET LIMIT **(includes Deductible, Coinsurance, Copayments, and cost sharing for Prescription drug coverage)**	N/A	$1,250/Individual $3,250/Family
LIFETIME MAXIMUM	Unlimited	Unlimited

COST SHARE CREDIT

If on the day before the effective date of this benefit booklet, a member was covered under a group major medical or extended medical contract issued to your group by us or another carrier, any covered expenses applied to the in-network and out-of-network deductible and in-network and out-of-network out-of-pocket limit incurred by the member under the prior group contract during the same benefit period will be applied to the satisfaction of any in-network and out-of-network deductible and in-network and out-of-network out-of-pocket limit required under this benefit booklet during the same benefit period for such member, for that year only. This applies only to members who are covered on the initial effective date of the new benefit booklet with us.

HOW TO ACCESS PRIMARY AND SPECIALTY CARE SERVICES

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Empire member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

WHEN YOU NEED CARE AFTER NORMAL OFFICE HOURS

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

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 1-855-519-9537
Call 1-800-810-BLUE (2583) or visit *www.bcbs.com* to locate participating BlueCard PPO® providers.

TRANSITIONAL CARE

Networks grow and change, and sometimes a provider will move or leave the network that serves your Plan. If you are an existing member and the provider with whom you are in an ongoing course of treatment leaves the network, Empire will notify you at least 30 calendar days prior to the physician's termination or within 15 days after we become aware of the provider's change in status.

You may continue to receive medically necessary covered services from a provider for an ongoing course of treatment for up to 90 days after he/she leaves the network, if the provider agrees to (1) reimbursement at the rates applicable prior to start of transitional care, (2) to adhere to the plan's quality assurance requirements, (3) to provide the plan with necessary medical information related to this care, and (4) to adhere to the plans policies and procedures. After 90 days, you must select a new provider. Continued care is available to pregnant women who are in the second and third trimester through the delivery and postpartum period. You must contact our Medical Management department to arrange this continued care.

Transitional care will not be approved if the provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

New plan members who are in treatment for a disabling and degenerative or life threatening condition or disease are eligible for up to 60 days of continued care following their initial enrollment date. Members who are pregnant and in their second or third trimester on the effective date of coverage may continue care through delivery and the postpartum period. The provider must agree to (1) reimbursement at the rates applicable prior to start of transitional care, (2) to adhere to the plan's quality assurance requirements, (3) to provide the plan with necessary medical information related to this care, and (4) to adhere to the plans policies and procedures, in both situations. You must contact our Medical Management department to arrange this continued care.

INTER-PLAN PROGRAMS

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may

be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

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

Non-Participating Healthcare Providers Outside Empire's Service Area

Your Liability Calculation

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

Exceptions

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

BLUECARD® PPO PROGRAM

Care When you are Out of Our Service Area Within the U.S.

If you are traveling outside the Empire service area, the BlueCard® PPO program lets you use other Blue Cross and/or Blue Shield plans' PPO networks of physicians, hospitals and other health care providers. As a PPO member, you are automatically enrolled in the BlueCard® PPO program. This allows you to receive in-network benefits across the country outside of our network area from providers participating with other Blue Plans' PPO networks. As long as these services are covered services under your Contract or Certificate, they will be treated as in-network services. If you are traveling and need medical care, call 1-800-810-BLUE (2583), for the names and addresses of the PPO providers nearest you. You may also visit the Blue Cross and Blue Shield Association Web site to locate providers in other states at www.bcbs.com.

BlueCard® Worldwide Program

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

- Call 1-804-673-1177, 24 hours a day, seven days a week, for the names of participating doctors and hospitals. Outside the U.S., you may use this number by dialing an AT&T Direct®[1] Access Number.
- Show your Empire ID card at the hospital. If you're admitted, you will only have to pay for expenses not covered by your contract, such as co-payments, coinsurance, deductibles and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive outpatient hospital care or care from a doctor in the BlueCard Worldwide Program, pay the bill at the time of treatment. When you return home, submit an international claim form and attach the bill. This claim form is available from the healthcare provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. You will receive reimbursement less any coinsurance amount above the maximum allowed amount..

Your Benefits at a Glance

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

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	IN-NETWORK	OUT-OF-NETWORK
HOME/OFFICE VISITS	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
ONLINE VISITS	$15 Primary co-payment per visit	Deductible and 20% coinsurance
SPECIALIST VISITS	$20 co-payment per visit	Deductible and 20% coinsurance
CHIROPRACTIC CARE* • Up to an annual in-network and out of network maximum of $1,000	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
SECOND OR THIRD SURGICAL OPINION	$10 co-payment per visit	Deductible and 20% coinsurance
DIABETES EDUCATION AND MANAGEMENT	$10 co-payment per visit	Deductible and 20% coinsurance
ALLERGY CARE • Office Visit • Testing • Treatment	$15 per visit (Non-Specialist) $20 per visit (Specialist) $0 $0	Deductible and 20% coinsurance
SURGERY	$0	Deductible and 20% coinsurance

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

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

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Laboratory tests	$0 $0	Deductible and 20% coinsurance
CHEMOTHERAPY	$0	Deductible and 20% coinsurance
HIGH COST DIAGNOSTIC TESTS (i.e. MRIs/MRAs, Nuclear cardiology services,PET/CAT scans)	$0	Deductible and 30% coinsurance
RADIATION	$0	Deductible and 20% coinsurance
PRE-SURGICAL TESTING	$0	Deductible and 20% coinsurance
ANESTHESIA	$0	Deductible and 20% coinsurance
KIDNEY DIALYSIS	$0	Deductible and 20% coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
CARDIAC REHABILITATION	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance

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

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL PHYSICAL EXAM • One per calendar year	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Not covered
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Over age 50-: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age – Diagnostic PSA: 1 per year	$0 $0 $0 $0	Deductible and 20% coinsurance
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment – Ages 55 through 65 - 1 baseline – Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)* • Mammogram (based on age and medical history) – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year • Women's sterilization procedures and counseling • Breastfeeding support, supplies and counseling – One breast pump per pregnancy • Screenings and/or counseling for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections STIs), Human immune deficiency (HIV), interpersonal and domestic violence.	$15 per visit (Non-Specialist) $20 per visit (Specialist) $0 $0 $0 $0 $0 $0	Deductible and 20% coinsurance
WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits – Newborn: 2 in-hospital exams at birth following vaginal delivery – Newborn: 4 in-hospital exams at birth following c-section delivery • Office visits – From birth up 1st birthday: 7 visits – Ages 1 through 4 years of age: 6 visits – Ages 5 through 11 years of age: 7 visits – Ages 12 up to 17 years of age: 6 visits – Ages 18 to 19th birthday: 2 visits • Lab tests • Immunizations (office visits are not required)	$0 $0 $0 $0	$0 $0 Deductible and 20% coinsurance Deductible and 20% coinsurance

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

See the Preventive Care section for more details.

	YOU PAY	
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
EMERGENCY ROOM	$75 per visit co-payment (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	$0	Covered in-network when specified criteria is met; subject to any applicable cost sharing. You may be required to pay the difference between the maximum allowed amount and the total charges of an out-of-network provider.
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the maximum allowed amount	Covered in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the maximum allowed amount and the provider's total charges.*
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

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

* *New York State law prohibits* ***land*** *ambulance providers in New York State from balance-billing beyond reasonable and customary amounts (you will be responsible for in-network cost share such as co-payments, deductibles and coinsurance).*

	YOU PAY	
HOSPITAL SERVICES*	**IN-NETWORK**	**OUT-OF-NETWORK*** **
SEMI-PRIVATE ROOM AND BOARD	$0	Deductible and 20% coinsurance
ANESTHESIA AND OXYGEN	$0	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
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	Deductible and 20% coinsurance
SURGERY (Inpatient and Outpatient) **	$0	Deductible and 20% coinsurance
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK**
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	$0	Not covered
ORTHOTICS	$0	Not covered
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	$0	Not covered
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	$0	Difference between the maximum allowed amount and the total charge (coinsurance does not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products) ****	$0	Deductible and 20% coinsurance
HEARING AIDS (one device per ear, every 3 years maximum of $1500 combined in and out-of-network)	$0	Deductible and 20% coinsurance

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

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* *Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation.*

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

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

	YOU PAY	
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY Up to 120 days per calendar year	$0	Not covered***
HOSPICE Unlimited 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	Deductible and 20% coinsurance only. ***
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**	$20 per visit (Specialist)	Deductible and 20% coinsurance
• Up to 60 visits combined in home, office or outpatient facility per calendar year	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
OCCUPATIONAL AND SPEECH THERAPY • Up to 60 visits per person combined in home, office or outpatient facility per calendar year	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance
VISION THERAPY • Up to 60 visits per person combined in home or office per calendar year	$15 per visit (Non-Specialist) $20 per visit (Specialist)	Deductible and 20% coinsurance

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

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

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

	YOU PAY	
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT • Up to 60 visits per calendar year [1]	$25 co-payment	Deductible and 20% coinsurance
INPATIENT • Up to 90 days per calendar year [1] • Up to 90 visits from mental health care professionals per calendar year [1]	$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 [1]	$0	Deductible and 20% coinsurance
INPATIENT • Up to 7 days detoxification per calendar year [1] • Up to 30 days rehabilitation per calendar year [1]	$0 $0	Deductible and 20% coinsurance Deductible and 20% coinsurance
PHARMACY (RETAIL AND MAIL SERVICE)	**IN-NETWORK**	**OUT-OF-NETWORK**
RETAIL PHARMACY (34 day supply) • **Tier 1** • **Tier 2** • **Tier 3**	20% co-payment, $5 minimum and up to a maximum of $20 per prescription 25% co-payment, $5 minimum and up to a maximum of $30 per prescription 25% co-payment, $5 minimum and up to a maximum of $30 per prescription	40% Coinsurance (within the United States) 20% Coinsurance (outside the United States)
MAIL SERVICE (90 day supply-includes some specific Retail locations)	$15 co-payment	Not covered
Generic and Select Oral Contraceptives and Contraceptive Devices	$0 cost share	Not covered
(All of the prescription drug options listed above meet the Centers for Medicare and Medicaid Services (CMS) standards for Medicare prescription drug coverage and each option is considered Creditable Coverage under the Medicare Modernization Act of 2003.)		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
SEX CHANGE SURGERY OR TREATMENT OF GENDER IDENTITY DISORDERS (for hospital inpatient only) • Lifetime Maximum $75,000 for transformative surgeries; Lifetime Maximum combined In-network and Out-of-Network	$0	Deductible and 20% coinsurance

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

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

Tips For Visiting Your Doctor

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

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

WOMEN'S HEALTH AND CANCER RIGHTS OF ACT 1998

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

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

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

What's Covered

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

- Consultation requested by the attending physician for advice on an illness or injury

  This includes the Specialist e-Consultations Program. If Your Participating Provider is in Our Cooperative Care program and is rendering primary care services to You, he or she may request an electronic consultation with a Specialist to help evaluate Your condition or diagnosis. The electronic consultation will be provided by a Participating Provider who has agreed to participate in Our "econsultation" program and will be selected by Your Participating Provider in his or her clinical judgement. The electronic consultation will be at no cost to You. Your Participating Provider may consider the information provided by the Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies such as secure web-based email, fax and/or exchange of electronic medical records. The results may be documented in an electronic health record.

- Diabetes supplies prescribed by an authorized provider:
  - Blood glucose monitors, including monitors for the legally blind

- Testing strips
- Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices
- Oral agents for controlling blood sugar
- Other equipment and supplies required by the New York State Health Department
- Data management systems

- Diabetes self-management education and diet information, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis
    - When the patient's condition changes significantly
    - When medically necessary
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  - Home visits for education when medically necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Gender Reassignment Surgery and related non-cosmetic services
  - Lifetime Maximum benefit of $75,000 for transgender surgery
  - Counseling Services are covered. These services will not count toward the $75,000 Lifetime Maximum Benefit.
- Cosmetic Services received in association with gender transformation are NOT covered, including:
  - Reduction Thyroid Chondroplasty
  - Liposuction
  - Rhinoplasty
  - Facial Bone Reconstruction
  - Face Lift
  - Blepharoplasty
  - Voice Modification Surgery
  - Hair Removal/hairplasty
  - Breast Augmentation

ONLINE VISITS

Your coverage includes online physician office visits. Covered Services include a medical consultation using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed primary care physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

Online visits are not meant for the following purposes:

To get reports of normal lab or other test results;
To request an office appointment;
To ask billing, insurance coverage or payment questions;
To ask for a referral to a specialist Doctor;
To request precertification for a benefit under your health Plan; or
To ask the physician to consult with another physician.

You must have the following computer hardware in order for the online website to work properly: USB or built in webcam (to enable two-way video during web conversations); and audio functionality. To minimize audio feedback, use a headset or headphones with a built-in microphone. To begin the online visit, log on to www.livehealthonline.com and establish an

online account by providing some basic information about you and your insurance plan. Before you connect to a Doctor, you will be asked: the kind of condition you want to discuss with the Doctor, list your local pharmacy, provide information for the credit card you want your cost share for the visit to be billed to, agree to the terms of use, and select an available physician. If you are not in New York State when you seek an online visit, you will need to check to be sure an online Doctor is available in the state you are in because online Doctors are not available in every state.

The visit with the physician will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access your records and print them, and may email or fax them to your primary care physician.

Clinical Trials

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this booklet.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

What's Not Covered

The following medical services are not covered:

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

Emergency Care

IF YOU NEED EMERGENCY CARE

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

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

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

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

Emergency Services are not subject to prior authorization requirements.

Emergency Assistance 911

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

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

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

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

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. 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.

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

What's Not Covered

These emergency services are not covered:

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

Emergency Air Ambulance

We will provide in-network coverage for air ambulance services when needed to transport you to the nearest acute care hospital in connection with an emergency room or emergency inpatient admission or emergency outpatient care, subject to cost sharing obligations, 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 maximum allowed amount that would be paid for land ambulance to that hospital. You may be required to pay the difference between the maximum allowed amount and the total charges of an out-of-network provider.

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

Emergency Land Ambulance

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

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

Non-Emergency Ambulance Transportation

We cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute Facility to a sub-Acute setting.

Limitations/Terms of Coverage

- We do not cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved by us, even though prescribed by a Physician.
- We do not cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when your medical condition is such that transportation by land ambulance is not appropriate; and your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one of the following is met:
  - The point of pick-up is inaccessible by land vehicle; or
  - Great distances or other obstacles (for example, heavy traffic) prevent your timely transfer to the nearest Hospital with appropriate facilities.

Maternity Care

IF YOU ARE HAVING A BABY

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

For out-of-network maternity services, you pay the deductible, coinsurance and any amount above the maximum 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

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

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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

What's Covered

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

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

What's Not Covered

These maternity care services are not covered:

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

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

Hospital Services

IF YOU VISIT THE HOSPITAL

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

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

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

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

Tip For Getting Hospital Care

- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

Inpatient And Outpatient Hospital Care

What's Covered

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

- Diagnostic X-rays and lab tests, and other diagnostic tests such as EKGs, EEGs or endoscopies
- Oxygen and other inhalation therapeutic services and supplies and anesthesia (including equipment for administration
- Anesthesiologist, including one consultation before surgery and services during and after surgery
- Blood and blood derivatives for emergency care, same-day surgery, or medically necessary conditions, such as treatment for hemophilia
- MRIs/MRAs, PET/CAT scans and nuclear cardiology services

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

Inpatient Hospital Care

What's Covered

Following are additional covered services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician, and
  - A hospital stay is medically necessary.
- Coverage is for unlimited days, 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
- Residential treatment services are not covered.

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

Outpatient Hospital Care

What's Covered

Following are additional covered services for same-day care:

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

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

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

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

Outpatient Hospital Care

What's Not Covered

These outpatient services are not covered:

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

Durable Medical Equipment and Supplies

IF YOU NEED EQUIPMENT OR MEDICAL SUPPLIES

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

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

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 1-855-519-9537.

Disposable medical supplies, such as syringes, are covered up to the maximum 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's pharmacy program, you may order these formulas or supplements through Empire's pharmacy program.

What's Covered

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

- Prosthetics, orthotics and durable medical equipment from network suppliers, when prescribed by a doctor, 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.
- Hearing aids and the examination for their fitting

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

What's Not Covered

The following equipment is not covered

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

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

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

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

Skilled Nursing Care

What's Covered

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

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

What's Not Covered

The following skilled nursing care services are not covered:

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

Hospice Care

Empire covers unlimited 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 twelve (12) months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

What's Covered

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

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

Tips for Receiving Skilled Nursing and Hospice Care

- To learn more about a skilled nursing facility, ask your doctor or caseworker to see the Health Facilities directory.
- For hospice care in your home, ask whether the same caregiver will come each day, or whether you will see someone new each time. What recourse do you have if you are not comfortable with the caregiver?

Home Health Care

IF YOU NEED HOME HEALTH CARE

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

Home infusion therapy, a service sometimes provided during home health care visits, is only available in-network. An Empire network home health care agency or home infusion supplier cannot bill you for covered services. If you receive a bill from one of these providers, contact Member Services at 1-855-519-9537.

What's Covered

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

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

What's Covered

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

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

What's Not Covered

The following home health care services are not covered:

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

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

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

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

Tip for Receiving Therapy

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

What's Covered

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

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

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

What's Not Covered

The following therapy services are not covered:

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

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

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

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

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

Mental Health Care

What's Covered

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

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

What's Not Covered

The following mental health care services are not covered:

- Care that is not medically necessary
- Out-of-network inpatient mental health care at a facility that is not an acute care general hospital
- Residential treatment services

Treatment for Alcohol or Substance Abuse

What's Covered

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

- Family counseling services at an outpatient treatment facility. These can take place before the patient's treatment begins. Any family member covered by the plan may receive 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.

What's Not Covered

The following alcohol and substance abuse treatment services are not covered

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

Empire's Pharmacy Program

YOUR PHARMACY BENEFITS PROGRAM

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

FILLING A PRESCRIPTION

When you have a prescription filled, you must pay the pharmacy the cost share amount for each separate prescription or refill. We will pay the pharmacy directly for the remainder of the cost of the prescription or refill. The Maximum Allowed Amount for covered Prescription Drugs is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM). The amount of the cost share for your prescription drug coverage is listed in Your Benefits At A Glance chart.

EMPIRE'S DRUG FORMULARY

Empire uses a preferred drug formulary which is a list of generic and preferred brand drugs that is distributed to participating pharmacies and providers and is subject to periodic review and modification by Us. Your doctor is encouraged to prescribe generic-equivalent drugs as appropriate when possible and to prescribe drugs from the preferred drug formulary when prescribing brand-name drugs.

The Preferred Formulary has three tiers:

Tier 1 drugs generally have the lowest Cost Share. This tier contains preferred medications that are generic, single source brand drugs, or multi-source brand drugs.

Tier 2 drugs generally have a higher Cost Share than those in Tier 1. This tier contains preferred medications that are generic, single source brand drugs, or multi-source brand drugs.

Tier 3 drugs generally have a higher Cost Share than those on Tier 2. This tier contains non-preferred medications that are generic, single source brand drugs, or multi-source brand drugs.

Preferred Generics

For most Prescription Drugs, You pay only the Cost-Sharing in the Your Benefits at a Glance section of the booklet. An additional charge, called an "ancillary charge," may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at You or Your Provider's request, and Our formulary includes a chemically equivalent Prescription Drug is available on a lower tier. You will have to pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.

Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment / Coinsurance. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

Tier Assignment Process. Empire's Pharmacy and Therapeutics (P&T) Committee consists of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs and advising on programs designed to help improve delivery of care. Such programs may include drug utilization programs, prior authorization criteria, therapeutic conversion programs, and drug profiling initiatives. The determination of tiers is made based upon clinical decisions provided by the P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate, certain clinical economic factors.

Empire retains the right to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another Tier.

The formulary and procedures are made available to all network providers at least once a year, or sooner if there are changes.

SPECIALTY DRUGS

You or your Physician are required to order your Specialty Drugs directly from a Network Specialty Pharmacy. "Specialty Drugs" are prescription drugs which:

- Are approved to treat limited patient populations, indications or conditions;
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support any or all of which make the drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, up to a thirty (30) day supply for retail and mail service, and subject to the applicable Deductible, Coinsurance or Copayment shown in the Your Benefits At A Glance chart.

Network Specialty Pharmacies have dedicated patient care coordinators to help you obtain prior authorization, if applicable, manage your condition, and offer toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications.

You may obtain a list of the Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on the back of your ID card, or review the lists on our website at www.empireblue.com, select "Pharmacy" under the "Plans and Benefits" tab of the "Member Home" page.

In addition, certain drugs that must be administered by a physician or other authorized practitioner are required to be ordered from our Network Specialty Pharmacy in order to be covered as a medical benefit. If you require one of these drugs, your physician or other treating practitioner will order the drug from the required pharmacy. You will not be required to fill a prescription for this category of drug.

SPECIAL PROGRAMS

From time to time we may initiate various programs to encourage Covered Persons to utilize more cost-effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, over the counter (OTC), or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

REMEMBER	**Benefits are only available for prescriptions filled at network pharmacies or through Empire's mail order.**

NETWORK PHARMACY

You must fill a prescription at an Empire network pharmacy for up to a 34-day supply of FDA-approved drugs, if prescribed by a physician or other licensed provider. Empire's pharmacy program offers:

- **Low cost**. You can receive up to a 34-day supply for each drug for a single co-payment.
- **Convenience**. You must present your Empire ID card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program.
- **No claim forms!** Under your policy guidelines, paper claims cannot be submitted. The pharmacist must submit your claim when you fill the prescription.

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's pharmacy program at 1-800-342-9816. You can also call when you are away from home for the name and location of the nearest participating pharmacy.

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

SAVE MONEY WITH EMPIRE'S MAIL ORDER PRESCRIPTIONS

Certain Prescription Drugs may be ordered through our mail order pharmacy. You can reduce your drug co-payments by using Empire's pharmacy mail order because you can receive up to a 90-day (three-month) supply of your medication on a single prescription for only one co-payment. This service is ideal for members who take the same medication on an on-going basis.

The same prescriptions filled at a participating pharmacy cost three co-payments for a three-month supply of medication—one co-payment for each 34-day supply.

In addition, Empire waives drug deductibles when you use the mail order. Deductibles still apply if you fill your prescriptions at a pharmacy.

Home Delivery for Maintenance Medications – If you are taking a Maintenance Medication, you may get the first 30-day supply and two 30-day refills of the same Maintenance Medication at your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if you would like to keep getting your 30-day supply of Maintenance Medications from your local Retail Pharmacy or if you would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication you get without registering your choice through the Home Delivery Pharmacy. You can tell us your choice by phone at the number on the back of your ID Card or by visiting our website.

How to Order Your Prescription by Mail

- Ask your doctor to write a prescription for each of your medication(s) that covers a 90-day supply as well as three refills. (Example: If you take 2 pills per day, the prescription should be written for 180 pills plus three refills.)
- Complete the mail order form you received in the mail with your ID card(s). You can get additional forms by going to *www.empireblue.com* or calling Empire's pharmacy program at the number on the back of your member ID card.
- Place your order for a refill at least three weeks before your current supply will run out.
- You will receive your filled prescription at your home within 14 working days, postage paid. If you prefer, you can also choose faster shipping for an additional fee

Tips for Using Mail Order

The first time you fill a prescription through mail order, ask your physician for a second prescription for a four-week supply. You can fill the second prescription at a local pharmacy so you have the medication until the mail order is processed.

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."

Empire's Pharmacy Program Customer Service: 1-800-342-9816

What's Covered

The following prescription drugs are covered:

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

What's Not Covered

The following items are not covered:

- Drugs or devices that do not require a prescription or are available over the counter, except insulin and diabetic supplies
- Devices of any type, such as therapeutic devices, IUD's, artificial appliances, hypodermic needles, syringes or similar devices, except where specifically covered, and except for bone density testing and treatment devices
- Charges or fees for drug administration or injection
- Vitamins that by law do not require a prescription
- Investigational or experimental drugs (i.e., medications used for experiments and/or dosage levels determined by Empire to be experimental) Refer to the Exclusions and Limitations Section and also the Complaints, Appeals and Grievances Section.

- Drugs received while in a hospital, nursing home or other facility (covered under medical plan as indicated)
- Appetite suppressants, unless medically necessary
- Compounded medications with no ingredients that require a prescription
- Medications for cosmetic purposes only
- Medications not approved by the FDA, unless otherwise required by law (i.e., drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA and not considered investigational or experimental)
- Replacement of lost, stolen or damaged prescription medications
- The cost for medication in excess of plan limits
- Refills not dispensed in accordance with the prescription
- Refills beyond one year from the original prescription date

SCHEDULE A.1

Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Pain Relief	Abstral
Arthritis	Actemra
Pain Relief	Actiq
Pulmonary Arterial Hypertension	Adcirca
Cancer Treatment	Afinitor
Psoriasis	Amevive
Multiple Sclerosis	Ampyra
Hormonal Therapy	Androderm
Hormonal Therapy	Androgel
Blood Builder	Aranesp
Hormonal Therapy	Arixion
Cancer Treatment	Avastin
Cervical Dystonia/Spasticity	Botox
Immune System/Immune Globulin	Carimune NF
Gaucher’s Disease	Ceredase
Gaucher’s Disease	Cerezyme
Arthritis/Crohn's Disease	Cimzia
Cervical Dystonia/Spasticity	Dysport
Cancer Treatment	Eligard
Arthritis/Psoriasis	Enbrel
Blood Builder	Epogen
Cancer Treatment	Erbitux
Arthritis	Euflexxa
Pain Relief	Fentora
Immune System/Immune Globulin	Flebogamma
Pulmonary Arterial Hypertension	Flolan
Osteporosis	Forteo
Hormonal Therapy	Fortesta
Immune System/Immune Globulin	Gamastan
Immune System/Immune Globulin	Gammagard liquid, S/D
Immune System/Immune Globulin	Gamunex
Multiple Sclerosis	Gilenya
Cancer Treatment	Gleevac
Cancer Treatment	Herceptin
Arthritis/Crohn's/Psoriasis	Humira
Arthritis	Hyalgan
Immune Deficiency	Increlex
Hepatitis	Infergen
Hepatitis	Intron-A
Arthritis	Kineret
Infection Prevention and Treatment	Lamisil
Blood Builder	Leukine
Cancer Treatment/Infertility	Leuprolide
Macular Degeneration	Lucentis
Endometriosis /Infertility/Cancer	Lupron, Depot
Seizures/Fibromyalgia/Nerve Pain	Lyrica
Macular Degeneration	Macugen
Cervical Dystonia/Spasticity	Myobloc
Blood Builder	Neulasta
Blood Builder	Neumega
Blood Builder	Neupogen
Cancer Treatment	Nexavar

SCHEDULE A.1 (continued)

Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Excessive Sleepiness	Nuvigil
Immune System/Immune Globulin	Octagam
Cancer Treatment	Oforta
Pain Relief	Onsolis
Arthritis	Orencia
Arthritis	Orthovisc
Immune System/Immune Globulin	Panglobulin
Hepatitis	Pegasys
Hepatitis	Peg-Intron
Infection Prevention and Treatment	Penlac
Immune System/Immune Globulin	Polygam S/D
Immune System/Immune Globulin	Privigen
Blood Builder	Procrit
Osteporosis	Prolia
Excessive Sleepiness	Provigil
Infection Prevention and Treatment	Qualaquin
Arthritis/Crohn's/Psoriasis	Remicade
Pulmonary Arterial Hypertension	Remodulin
Pulmonary Arterial Hypertension	Revatio
Cancer Treatment	Revlimid
Cancer Treatment	Rituxan
Hepatitis	Roferon-A
Arthritis/Psoriasis	Simponi
Excessive Sleepiness	Sporanox
Infection Prevention and Treatment	Sprycel
Arthritis/Crohn's/Psoriasis	Stelara
Opiod Dependence	Suboxone
Arthritis	Supartz
Precocious Puberty	Supprelin LA
Cancer Treatment	Sutent
RSV Prevention	Synagis
Precocious Puberty/Endometriosis	Synarel
Arthritis	Synvisc
Arthritis	Synvisc, One
Cancer Treatment	Tarceva
Cancer Treatment	Targretin
Cancer Treatment	Tasigna
Cancer Treatment	Temodar
Hormonal Therapy	Testim
Cancer Treatment	Thalomid
Cancer Treatment	Trelstar, Depot, LA
Cancer Treatment	Tykerb
Pulmonary Arterial Hypertension	Tyvaso
Cancer Treatment	Vantas Implant
Cancer Treatment	Vectibix
Pulmonary Arterial Hypertension	Ventavis
Infection Prevention and Treatment	Vfend
Immune System/Immune Globulin	Vivaglobin
Addiction Treatment	Vivitrol
Cancer Treatment	Votrient
Gaucher’s Disease	Vpriv
Cancer Treatment	Xeloda

SCHEDULE A.1 (continued)

Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Huntington's Disease	Xenazine
Bone Fracture/Pain Due to Cancer	Xgeva
Arthritis	Xiaflex
Antibiotic	Xifaxan
Asthma	Xolair
Gaucher’s Disease	Zavesca
Cancer Treatment	Zoladex
Cancer Treatment	Zolinza
Infection Prevention and Treatment	Zyvox

SCHEDULE A.2

Step Therapy Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Proton Pump Inhibitor	Aciphex
Antiacne	Adoxa
Antiallergy-opthalmic	Alamast
Non-Sedating Antihistamine	Allegra ODT, Suspension, D
Antiallergy-opthalmic	Alocril
Antiallergy-opthalmic	Alomide
Antihyperlipidemic	Altoprev
Sedative/Hypnotics	Ambien CR
CNS Stimulant	Amphetamine Salt Combo
Hypoglycemics	Apidra
Non-Steroidal Antiinflammatories	Arthrotec
Diabetes	Avandament
Diabetes	Avandaryl
Diabetes	Avandia
Migraine Medication	Axert
Diabetes	Blood Glucose Meters/Strips
Nasal Steroids	Beconase AQ
Antiacne - Topical	Benzaclin
Multiple Sclerosis	Betaseron
Osteoporosis	Boniva
Ovulatory Stimulants	Bravelle
Hypoglycemics	Byetta
Non-Steroidal Antiinflammatories	Celebrex
Non-Sedating Antihistamine	Clarinex-D
Non-Sedating Antihistamine	Clarinex, Suspension
Proton Pump Inhibitor	Dexilant
Antiacne	Doryx
Sedative/Hypnotics	Edluar
Antiallergy-opthalmic	Elestat
Dermatological Agent	Elidel
Antiallergy-opthalmic	Emadine
Overactive Bladder Agents	Enablex
Multiple Sclerosis	Extavia
Analgesics	Flector
Nasal Steroids	Flunisolide Nasal Spray
Overactive Bladder Agents	Gelnique
Ovulatory Stimulants	Gonal-F
Proton Pump Inhibitors	Kapidex
Antihyperlipidemic	Lescol, XL
Antihypertensive	Letairis
Antihyperlipidemic	Livalo
Antiacne	Minocin
Nasal Steroids	Nasacort AQ
Nasal Steroids	Nasarel
Nasal Steroids	Omnaris
Antiallergy-opthalmic	Optivar
Overactive Bladder Agents	Oxytrol
Proton Pump Inhibitors	pantaprazole
Proton Pump Inhibitors	Prilosec
Proton Pump Inhibitors	Prevacid
Proton Pump Inhibitors	Protonix
Dermatological Agent	Protopic

SCHEDULE A.2

Step Therapy Drugs Subject to Prior Authorization (continued)

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Drug Class	Prescription Drug
Migraine Medication	Relpax
Nasal Steroids	Rhinocort Aqua
Sedative/Hypnotics	Rozerem
Antiacne	Solodyn
Overactive Bladder Agents	Sanctura
Sedative/Hypnotics	Sonata
Migraine Medication	Sumavel DosePro
Migraine Medication	Treximet
Gout Medications	Uloric
Hypoglycemics	Victoza
Antihyperlipidemics	Vytorin
Non-Sedating Antihistamine	Xyzal, Syrup
Proton Pump Inhibitors	Zegerid
Antihyperlipidemics	Zetia
Skin Condition	Ziana
Sleep Aid	Zolpimist

Exclusions and Limitations

EXCLUSIONS

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

Dental Services

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

However, your plan does cover:

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

Experimental/Investigational Treatments

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

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

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

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

Government Services

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

Home Care

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

Inappropriate Billing

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

Medically Unnecessary Services

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

Not Medically Necessary Transgender Surgery

- Surgery and/or treatment for gender change that does not meet our medical criteria for medical necessity.

Prescription Drugs

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

Services Provided by a Family Member

- We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Sterilization/Reproductive Technologies

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

Travel

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

Vision Care

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

War

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

Workers' Compensation

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

LIMITATION AS INDEPENDENT CONTRACTOR

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

Health Management

Empire's Medical Management Program

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

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

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

Empire may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Empire's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services. In addition, we may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your Claim from medical review if certain conditions apply. Just because Empire exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Empire will do so in the future, or will do so in the future for any other Provider, Claim or Member. Empire may stop or modify any such exemption with or without advance notice. You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory or contacting customer service number on the back of your ID card.

How Empire's Medical Management Program Helps You

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

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

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

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

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

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 certain 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.

1. **Preauthorization Reviews.**

   a. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of the request.

   If We need additional information, We will request it within fifteen (15) calendar days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

   b. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

   If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

   c. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a

determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

2. **Concurrent Reviews**

   1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

      If We need additional information, We will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

   2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider within 24 hours of receipt of the request.

      If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

   3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

3. **Retrospective Reviews.** If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

   Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

4. **Retrospective Review of Preauthorized Services.** We may only reverse a preauthorized treatment, service or procedure on retrospective review when:
   - The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
   - The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
   - We were not aware of the existence of such information at the time of the Preauthorization review; and
   - Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

5. **Reconsideration.** If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same

clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider and in writing.

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

IF A REQUEST IS DENIED

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

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

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.

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 cost
- 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 this plan 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.

Preventive Services

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many Preventive Care Services are covered by this Benefit Program with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. These services fall under four broad categories as shown below:

A. Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;

   Examples of these services are screenings for:

   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High blood pressure;
   Type 2 diabetes mellitus
   Cholesterol;
   Child and adult obesity.

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations, including the well-child care immunizations as listed below:
   - DPT (diphtheria, pertussis and tetanus)
   - Polio
   - MMR (measles, mumps and rubella)
   - Varicella (chicken pox)
   - Hepatitis B Hemophilus
   - Tetanus-diphtheria
   - Pneumococcal
   - Meningococcal Tetramune
   - Other immunizations as determined by the Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") including:
   - Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.
   - Bone Density Testing and Treatment. Standards for determining appropriate coverage include the criteria of the federal Medicare program and the criteria of the National Institutes of Health for the Detection of Osteoporosis. Bone mineral density measurements or tests, drugs and devices include those covered under Medicare and in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy X-ray absorptiometry. Coverage shall be available as follows:

     For individuals who are:
     - Ages 52 through 65 - 1 baseline
     - Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)

- Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

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

D. Women's Preventive: Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

- Well-woman care visits to a gynecologist/obstetrician

- Women with no prior or family history of breast cancer, get a baseline mammogram between ages 35-39, and for ages 40 and over an annual mammogram. Women who have a family history of breast cancer will be covered for a routine mammogram at any age and as often as their physician recommends one.

- Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives.

  In addition, coverage is available for generic and single-source brand name prescription drugs for oral contraceptives and patches dispensed from a pharmacy. To obtain benefits, prescription drugs must be approved by the federal Food and Drug Administration and must be obtained from a retail or mail order pharmacy that is a member of our Pharmacy Network. Please see the Oral Contraceptive Prescription Drug Rider for more information.

- Breastfeeding support, supplies, and counseling: Covered in full when received from an In-Network Provider. Benefits for breast pumps are limited to one pump per Calendar Year.

- Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

The preventive services referenced above shall be covered in full when received from In-Network Providers. Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

A list of the preventive services covered under this paragraph is available on our website at *www.empireblue.com,* or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

VOLUNTARY CLINICAL QUALITY PROGRAMS

The purpose of these voluntary clinical quality programs is to promote good health and early detection of disease. They are designed to encourage eligible Members to obtain certain covered Preventive Care or other recommended care covered under this Certificate that was not received within the recommended timeframe. For instance, a program may be designed to encourage You to bring Your child to his or her PCP for a well-child or well-baby care visit if You missed a recommended check-up, or may encourage You to get certain screening tests such as a mammogram if You have not been tested within the recommended age range. Or, a program may encourage You to have a medical visit within a specific time period such as a postpartum checkup within a set number of days after delivery of a newborn or a home visit so you can provide a blood sample for a recommended laboratory test.

a. **Description.** These voluntary clinical quality programs are designed to encourage You to get certain preventive,

wellness, or other recommended care when You need it based on recommended clinical guidelines. These programs are not guaranteed and Your participation is optional. We will give You the choice, and if You choose to participate in any program for which You qualify, and obtain the recommended care within the program's timeframe, You will receive an incentive. The incentive will take the form of:

i. a gift card in the amount of $50 or retailer coupons, such as for discounts on eye glasses;
ii. a home test kit at no cost to allow you to conveniently collect a specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. In this case, You may need to pay any cost shares that normally apply to covered laboratory tests under your benefit plan, but the home test kit will be free to You. or
iii. a home visit to allow you to provide a specimen for certain covered laboratory tests, or for certain biometric screenings. In this care, You may need to pay any cost shares that normally apply to covered laboratory tests, but the home visit will be free to You.

If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, we recommend that you consult Your tax advisor.

b. **Eligibility.** You, the Subscriber, and the Subscriber's covered Spouse, and each covered Dependent can participate in the Voluntary Clinical Quality Program(s) if the targeted service applies, based on the recommended clinical guidelines the program promotes. These programs will be offered to Members who have certain conditions, who fall within certain age ranges, or who are due to receive certain recommended preventive or other care based on a recommended timeframe. For example:

i. Members age 50-75 years who have not undergone colorectal cancer screening as recommended by the American Cancer Society may be eligible to participate in a program designed to encourage these members to obtain a recommended preventive colorectal cancer screening, such as a fecal occult blood screening test.

ii. Members age 50-74 years who have not had a mammography screening as recommended by the United States Preventive Services Task Force may be eligible to participate in a program designed to encourage these members to obtain the screening through the offer of a gift card awarded upon receipt of documentation that the screening was completed.

c. **Participation.** If You are eligible for a clinical quality program we offer, we will contact You by phone or mail to offer You the chance to participate. You may also call us at the phone number on Your ID card if You have any questions regarding program participation. We will explain to You the care You are recommended to receive and the time frame within which You need to receive it to be in eligible for the reward if applicable.

d. **Rewards.** Rewards for participation in a clinical quality program and completion of the identified services within the specified timeframe include monetary rewards in the form of a gift card or retailer coupon such as for discounts on eye glasses, so long as the recipient is encouraged to use the reward for a product or service that promotes good health. In other cases, You will receive a home test kit at no cost to make it more convenient for You to receive the recommended care.

Wellness Programs

A. Purpose. The purpose of Our wellness program(s) is to encourage You to take a more active role in managing Your health and well-being. Our wellness-related programs are designed to help You achieve Your best health. These programs are not Covered services under Your Plan, but are separate components which are not guaranteed under Your Plan and could be discontinued at any time. Participation is voluntary, and You can discontinue the program at any time.

B. Description. We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

1. **Health Assessment Completion.** A Health Assessment is an online health tool. You will answer questions about Your lifestyle, current health and history. You will have access to a personal report with health tips and available online programs.
   - **Eligibility.** The Subscriber and the Subscriber's covered Spouse or Domestic Partner age 18 and older can participate in the program.
   - **Participation.** To access the Health Assessment, register or log in to Our website at *www.empireblue.com*. If You haven't set up a user name and password, select Register Now to set them up. Then click on the Health & Wellness tab and select "Take my HA now" to complete the assessment. On Your first visit to the site, You'll be asked to give Your email address and choose health topics of interest. If You do not have access to a computer, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access. We will provide You with a paper Health Assessment that will allow You to participate without computer access.

2. **Future Moms.** Future Moms is a maternity management program which provides individualized support to expectant moms to help them achieve healthier pregnancies and deliveries. The program provides education and support for high-risk and non-high-risk expectant mothers.
   - **Eligibility.** The Subscriber and the Subscriber's covered Spouse or Domestic Partner age 18 and older can participate in the program.
   - **Participation.** Expectant moms can sign up and enroll by calling Us toll free at 800-828-5891. One of Our registered nurses will help You get started.

3. **Behavioral Health Resource.** Our Behavioral Health Resource program provides individualized support from care managers to members with behavioral health conditions, such as depression and anxiety. Care managers are licensed mental health professionals whose goals are to help you take control of your health care and improve your quality of life. Members have access to:
      - Our telephonic behavioral health resource center, available 24 hours a day 7 days a week, for assessment, referral, education, coaching, and crisis resolution, including depression care management, eating disorder management, and management of other complex behavioral health concerns.
      - The program's online and mobile app wellness tools. These tools offer customized ways to address topics such as: stress management, anxiety, depression, substance abuse, and chronic pain. The program employs personalized tools, evidence-based resources, and individually-tailored eLearning programs to help members learn and practice new ways to manage their mental well-being.
   - **Eligibility.** The Subscriber and each covered Dependent are eligible for the program.
   - **Participation.** You may call Us toll free at the number on Your ID card. A care manager will help You get started. In addition, We may use claims history to identify and contact potential candidates by phone to discuss whether the program is right for them.

Details and Definitions

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

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

Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit *www.empireblue.com* or call Member Services at 1-855-519-9537.

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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 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*.

Assignment

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

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

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

Tips for Filing a Claim

- File claims within 18 months of date of service.
- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-855-519-9537. to have one mailed to you.
- Complete all information requested on the form.
- Submit all claims in English or with an English translation.
- Attach original bills or receipts. Photocopies will not be accepted.
- If Empire is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill.
- Keep a copy of your claim form and all attachments for your records.

REMEMBER	File claims within 24 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.

FRAUD AND ABUSIVE BILLING

We have processes to review claims before and after payment to detect fraud and abusive billing. In addition, We may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected for review under this program, then as part of the review process We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Which Plan Pays Benefits First?

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

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

If Empire Is the Secondary Plan

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

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.

- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

If You Receive An Overpayment Of Benefits

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

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

Subrogation and Right of Reimbursement

These provisions apply when Plan benefits are paid as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Administrator, on behalf of the Employer, has the right to recover Plan payments made on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Administrator, on behalf of the Employer, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of the Employer, to exercise their rights and do nothing to prejudice them.
- The Administrator, on behalf of the Employer, has the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Administrator's subrogation claim and any claim still held by you. The Administrator’s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

The Administrator, on behalf of the Employer, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Administrator, on behalf of the Employer, further agrees that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Administrator, on behalf of the Employer.

Reimbursement

If you obtain a Recovery and the Administrator, on behalf of the Employer, has not been repaid for the benefits the Administrator, on behalf of the Employer, paid on your behalf, the Administrator, on behalf of the Employer, shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Administrator, on behalf of the Employer, to the extent of Plan benefits the Administrator, on behalf of the Employer, paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Administrator, on behalf of the Employer, shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Administrator, on behalf of the Employer, the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Administrator, on behalf of the Employer, immediately upon your receipt of the Recovery. You must reimburse the Employer, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Administrator, on behalf of the Employer.
- If You fail to repay the Administrator, on behalf of the Employer, the Administrator, on behalf of the Employer, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Administrator, on behalf of the Employer, has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  - The amount the Administrator, on behalf of the Employer, paid on your behalf is not repaid or otherwise recovered by the Administrator, on behalf of the Employer; or
  - You fail to cooperate.
- In the event that You fail to disclose to the Administrator and/or the Employer the amount of your settlement, the Administrator, on behalf of the Employer, shall be entitled to deduct the amount of their lien from any future benefit under the Plan.

- The Administrator, on behalf of the Employer, shall also be entitled to recover any of the unsatisfied portions of the amount they have paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Administrator, on behalf of the Employer, has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Administrator, on behalf of the Employer, would not have any obligation to pay the Provider.

The Administrator, on behalf of the Employer, is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify the Administrator, on behalf of the Employer, promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Administrator, on behalf of the Employer, in the investigation, settlement and protection of the Employer's rights of the Administrator, on behalf of the Employer.
- You must not do anything to prejudice the rights of the Administrator, on behalf of the Employer.
- You must send the Administrator, on behalf of the Employer, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Administrator, on behalf of the Employer, if you retain an attorney or if a lawsuit is filed on your behalf.

Health Care Fraud

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

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

If You Have Questions About a Benefit Payment

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

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

The notification will give you:

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

If you have any questions about your claim, your Benefits Administrator may be able to help you answer them. You may also contact Empire Member Services at 1-855-519-9537 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

Reimbursement For Covered Services

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the Blue Cross and Blue Shield Association BlueCard Program section for additional information regarding services received outside of Empire's service area.

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

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

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

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and determine, among other things, the appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means We have determined that the claim submitted was inconsistent with procedure coding rules and/or our reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with Empire to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for that service, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent that you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit www.empireblue.com.

Providers who have not signed any contract with Us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross and Blue Shield Association rules governing claims filed by certain ancillary Providers.

For Covered Services that you receive from an Out-of-Network Provider, the Maximum Allowed Amount will be based on our Out-of-Network Provider fee schedule/rate or the Out-of-Network Provider's charge, this amount is currently 275% of Medicare's Fee Schedule ,whichever is less (except Certified Social Worker 225% and Physical Therapy 200%). Our Out-of-Network Provider fee schedule/rate may be accessed by calling the Customer Service number on the back of your identification card. The Maximum Allowed Amount on our Out-of-Network Provider fee schedule/rate has been developed by reference to one or more of several sources, including the following:

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

The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

For Covered Services rendered outside Empire's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price.

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

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

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

MEMBER COST SHARE

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

Your cost share amount and out-of-pocket limit may vary depending on whether you received services from an In-Network or an Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the terms of this Benefit Booklet and Benefits At A Glance chart for your cost share amounts and limitations, or call Customer Service to learn how Your Plan's benefits or cost share amounts may vary by the type of Provider you use.

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

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Facility and receive Covered Services from an Out-of-Network

Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only. Please see Your Benefits At A Glance for Your applicable amounts.

Example: Your Plan has Coinsurance of 20% for In-Network services, and 30% Out-of-Network after the In- or Out-of-Network Deductible has been met. You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

The Out-of-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; your Coinsurance responsibility is 20% of $950, or $190; and the remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total out of pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.

You choose an In-Network surgeon. The charge is $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.

You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; your Coinsurance for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total out of pocket charge would be $450 plus an additional $1000, for a total of $1450.

AUTHORIZED SERVICES

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

The following are examples for illustrative purposes only. Please see Your Benefits At A Glance chart for Your applicable amounts.

Example: You require the services of a specialist; but there is no In-Network Provider for that specialty in your state of residence. You contact Us in advance of receiving any Covered Services, and We authorize you to go to an available Out-of-Network Provider for that Covered Service and We agree that the In-Network cost share will apply.

Your Plan has a 30% Coinsurance for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and Empire will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

Complaints, Appeals and Grievances

Grievance Procedures

A. **Grievances.** Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. **Filing a Grievance.** You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. **Grievance Determination.** Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. **Grievance Appeals.** If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all

	necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

Utilization Review

1. **Utilization Review.** We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

   All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card, or visit Our website at *www.empireblue.com.*

2. **Utilization Review Internal Appeals.** You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

   You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

   1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
      - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and

- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

3. **First Level Appeal.**

   1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

   2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

   3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external review.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

   Substance Use Appeal. If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

4. **Second Level Appeal.** If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external review. **The four (4) month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file for external review.**

A second level Appeal must be filed within 60 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and inform You, if necessary, of any additional information needed before a decision can be made.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.]

External Review

A. If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

B. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

C. All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Ending and Continuing Coverage

WHEN COVERAGE ENDS

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

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

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

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

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

THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

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

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

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.

Certificates of Creditable Coverage After Termination

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

ACCESS TO INFORMATION

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

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

For Members Who Don't Speak English

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

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

Definitions

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

Adverse Determination

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

Annual Out-of-Pocket Limit

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

Authorized Services

See "precertified services."

Co-payment

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

Covered Services

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

Deductible

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

Hospital/Facility

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

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

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

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

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

For behavioral healthcare purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; or a facility that has a participation agreement with Empire to provide mental and behavioral healthcare

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

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

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

In-Network Benefits

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

In-Network Provider/Supplier

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

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

Itemized Bill

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

Lifetime Maximum

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

Maximum Allowed Amount (MAA)

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

Medical Necessity

We Cover benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it. We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service of sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or infusion of a specialty

drug provided in the outpatient department of a hospital if the drug could be provided in the physician's office of the home setting.

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 Deductible and Coinsurance

Out-of-network benefits for all services are paid after you meet an individual or family o*ut-of-network* deductible. Once your out-of-network deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called coinsurance, of Empire's maximum allowed amount for the o*ut-of-network* service. You are responsible for any amounts not covered, or which are in excess of the allowed amount. You pay your *out-of-network* coinsurance up to an annual out-of-pocket limit. Once you meet your annual o*ut-of-network* out-of-pocket limit, you will not be required to pay coinsurance, but you will be responsible to pay the difference between the provider's actual charge and Empire's allowed amount. This is not applied to the deductible and coinsurance amounts. Refer to Your *Benefits at a Glance* section for your *out-of-network* deductible, coinsurance and out-of-pocket limit amounts.

Out-of-Network Providers/Suppliers

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

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

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that:

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

Plan Administrator

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

Precertified Services

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

Provider

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

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

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

Same-Day Surgery

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

Treatment Maximums

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

AudioHealth Library Topics

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

Abdominal Problems

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

Allergies

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

Back and Neck Pain

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

Bone, Muscle and Joint Problems

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

Cancer

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

Chest, Respiratory and Circulatory Problems

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

Chronic Conditions

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

Ear, Nose and Throat

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

Eye Problems

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

First Aid and Emergencies

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

Headaches and Nervous System Problems

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

Home Health Medicines and Supplies

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

Infant and Child Health

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

Infant and Child Health

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

Infectious Diseases

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

Living Healthy

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

Medical Tests and Procedures

1506 Home Blood Sugar Monitoring
1532 Exercise Electrocardiography
1533 Complete Blood Count (CBC)
1534 Chest X-ray
1535 Chorionic Villus Sampling
1536 CT Scan of the Body
1537 Electroencephalogram
1538 Electrocardiogram
1539 Electromyography (EMG)
1540 Barium Enema
1541 Upper Gastrointestinal (GI) Series
1542 Magnetic Resonance Imaging
1546 Lung Function Tests

1547 Abdominal Ultrasound
2155 Cystoscopy
2156 Dilation and Curettage
2157 Episiotomy
2158 Surgery for Hemorrhoids
2159 Hernia Surgery
2160 Hip Replacement Surgery
2162 Arthroscopy
2163 Knee Replacement Surgery
2164 Laparoscopy
2165 Ear Tubes
2171 Tonsillectomy and Adenoidectomy
2503 Shared Decisions about Surgery

Men's Health

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

Mental Health Problems and Mind-Body Wellness

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

Partnership with your doctor

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

Senior Health

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

Skin Problems

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

Sleeping Disorders

2400 Sleep Problems
2403 Sleep Apnea
2406 Snoring

Women's Health

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

Women's Health

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

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

2016 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2016. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. References to "360° Health® Empire's Health Services Programs" are changed to "Health and Wellness Solutions".

B. The following is added to the Assignment of Benefits provision:

Any purported assignment of benefits shall be void. Any purported assignee of benefits shall acquire no rights by reason of any such purported assignment.

C. The following revisions apply to your Ambulatory Surgery benefit:

a. References to Ambulatory Surgery are hereby deleted and replaced with the following term:

Same Day surgery. Same-day or outpatient surgery is surgery performed in a hospital or other facility that does not require an overnight stay. For same-day surgery, the definition of "hospital" may include a free-standing ambulatory surgical facility that has a participation agreement with either Empire or another Blue Cross and/or Blue Shield plan. "Facility" does not include a provider's office.

b. i. The following provision is deleted from your Benefit Booklet:

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.

ii. The following provision is added to your Benefit Booklet:

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 hospital outpatient 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.

D. The following defined terms are added to your Benefit Booklet:

a. Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who

charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this benefit plan.

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

2017 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2017. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. The following is added to the Introduction section of your Benefit Booklet:

Your Employer has agreed to be subject to the terms and conditions of Empire's provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

B. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs.

1. **Out-of-Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve, (the "Empire Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

   Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.** BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments. Additional information is available upon request.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

5. **Non-Participating Providers Outside Our Service Area.**

    a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by Non-Participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

    b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by Non-Participating Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. **BlueCard Worldwide® Program.** If You plan to travel outside the United States, call Member Services to find out Your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

    When You are traveling abroad and need medical care, You can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

    If You need inpatient hospital care, You or someone on Your behalf, should contact Us for preauthorization. Keep in mind, if You need emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

    How claims are paid with BlueCard Worldwide. In most cases, when You arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:
    - Doctors services;
    - Inpatient hospital care not arranged through BlueCard Worldwide; and
    - Outpatient services.

    You will need to file a claim form for any payments made up front.

    When You need BlueCard Worldwide claim forms, You can get international claim forms in the following ways:
    - Call the BlueCard Worldwide Service Center at the numbers above; or
    - Online at *www.bluecardworldwide.com*.

    You will find the address for mailing the claim on the form.

C. **The Subrogation and Reimbursement provisions are hereby deleted and replaced with the following:**

Subrogation and Reimbursement

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

you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

1. Subrogation

   The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

   The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

   You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

   In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

   The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

   To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

   The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

2. Reimbursement

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

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

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

   You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan’s equitable lien applies is a Plan asset.

   Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

   You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

   If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

   The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
   You fail to cooperate.

In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan’s lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

3. Your Duties

You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.

You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

You must not do anything to prejudice the Plan's rights.

You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

D. Provision language related to Special Enrollment Periods is hereby deleted and replaced with the following:

You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;

6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice within 60 days of the loss of coverage. The effective date of Your coverage will be the date indicated on the application.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:
1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
2. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice within 60 days of one of these events.. The effective date of Your coverage will be the date indicated on the application.

E. The following is added to the Exclusions and Limitations section of Your Benefit Booklet.

- **Conversion Therapy.** We do not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

2018 AMENDMENT

This Amendment changes provisions in, or adds provisions to, your Benefit Booklet, including any affected riders, endorsements or other amendments thereto, issued by Empire upon your Plan's renewal on or after January 1, 2018. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Benefit Booklet ("Members"). All of the terms, conditions, and limitations of the Benefit Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

A. The following is added to the listing of services requiring prior authorization or precertification:

- Genetic Testing

B. The BlueCard and/or Inter-Plan Program provision language is hereby deleted and replaced with the following:

Inter-Plan Programs

1. **Out-of-Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside of the geographic area We serve (the "Empire Service Area"), the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

   When You receive care outside of the Empire Service Area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

2. **BlueCard® Program.** Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

   When You receive Covered Services outside the Empire Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

   Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **Special Cases: Value-Based Programs.** BlueCard® Program. If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part

of such an arrangement, except when a Host Blue passes these fees to Empire through average pricing or fee schedule adjustments.

4. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

5. **Non-Participating Providers Outside Our Service Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Empire's Service Area by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

   b. **Exceptions.** In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the Empire Service Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

6. **Blue Cross Blue Shield Global Core® Program.** If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance and Urgent Care outside of the United States. Remember to take an up to date health ID card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

How claims are paid with Blue Cross Blue Shield Global Core®. In most cases, when You arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When You need Blue Cross Blue Shield Global Core® claim forms, You can get international claim forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at*www.bcbsglobalcore.com*.

You will find the address for mailing the claim on the form.

C. **The "Initial Decisions" section of the "Health Management" chapter of your benefit booklet is hereby deleted and replaced with the following:**

5. **Preauthorization Reviews.**

   d. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of

receipt of the request.

If We need additional information, We will request it within fifteen (15) calendar days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

e. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

f. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

6. Concurrent Reviews

4. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

   If We need additional information, We will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

5. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider within 24 hours of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

6. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

7. **Retrospective Reviews.** If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period.

   Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

8. **Retrospective Review of Preauthorized Services.** We may only reverse a preauthorized treatment, service or procedure on retrospective review when:
   - The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
   - The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
   - We were not aware of the existence of such information at the time of the Preauthorization review; and
   - Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

D. Coverage for Online Visits is revised as follows:

- **Online visits.** Your coverage includes online physician office visits. Covered Services include a visit with the physician using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Online visits are not for specialist care. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature.

  Member Access. To begin the online visit, log on to *www.livehealthonline.com* and establish an online account by providing some basic information about You and Your insurance plan. Before You connect to a Doctor, You will be asked to identify: the kind of condition You want to discuss with the Doctor, list Your local pharmacy, provide information for the credit card You want Your cost share for the visit to be billed to, agree to the terms of use, and select an available Physician. If You are not in New York State when You seek an online visit, You will need to check to be sure an online Doctor is available in the state You are in because online Doctors are not available in every state.

  The visit with the Physician will not start until You provide the above information and click "connect." The visit will be documented in an electronic health record. You may access Your records and print them, and may email or fax them to Your Primary Care Physician.

  Note about Covered Services. Online visits are not meant for the following purposes:
  - To get reports of normal lab or other test results;
  - To request an office appointment;
  - To ask billing, insurance coverage or payment questions;
  - To ask for a referral to a specialist Doctor;
  - To request Preauthorization for a benefit under your health Plan; or
  - To ask the Physician to consult with another Physician.

E. The following provisions related to Claim Determinations are added to your benefit booklet:

1. **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Booklet for

information on how We coordinate benefit payments when You also have health coverage with another plan.

2. **Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at *www.empireblue.com*. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Booklet or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Booklet; on Your ID card or visiting Our website at *www.empireblue.com*.

3. **Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 18 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 18 month period, You must submit it as soon as reasonably possible.

4. **Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

5. **Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

   For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

6. **Pre-Service Claim Determinations.**

   1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

      If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

   2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee), within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours of receipt of the request. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) within 48 hours of the earlier of Our receipt of the additional information or, if information was not received, at the end of the 48-hour period allowed to submit the information.

7. **Post-Service Claim Determinations.** A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the

earlier of Our receipt of the information or the end of the 45 day period.

F. The definition of "Providers" is revised as follows:

- For behavioral healthcare purposes, "provider" includes care from licensed psychiatrists or psychologists; licensed clinical social workers; licensed mental health counselors; licensed marriage and family therapists; licensed psychoanalysts; licensed psychiatric nurse, licensed as a nurse practitioner or clinical nurse specialist or a professional corporation or a university faculty practice corporation thereof. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.

Get Help In Your Language

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bengali
আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID
卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Yiddish

דעם מעלדונג האט וויכטיגע אינפארמאציע וועגן אייער אפלעקאציע אדער קאווערידזש. קוקט פאר נויטיגע דאטעס אין דעם מעלדונג. איר וועט מעגליך דארפן נעמען אקציע קודם געוויסע דעדליינז צו האלטן אייערע געזונט קאווערידזש אדער העלפן מיט קאסט. איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. רופט די מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף(TTY/TDD:711).

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.