Niskayuna Central School District
Group 382047-T01

EPO

1/2007

Welcome!

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

YOUR EPO – A SMART WAY TO GET HEALTHCARE

Your EPO, or Exclusive Provider Organization, is a group healthcare plan available to you through an insurance policy issued and underwritten by Empire BlueCross. The EPO 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 to provide services to members as part of the plan's "network."

With Empire's EPO, when you need healthcare services, you are free to get care from any provider participating in Empire's network.

WHAT'S THE EPO ADVANTAGE?

When you use Empire's 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
- 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 temporarily living outside of Empire's service area

HOW TO USE THIS GUIDE

This Guide gives you an overview of the features and benefits of your EPO. 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:

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

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

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

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

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

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

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

ASSISTANCE IS A CLICK AWAY

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

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

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

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

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

YOUR PRIVACY IS PROTECTED

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

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

Your EPO Guide

Introduction

Using Your EPO

Coverage

Health Management

Details and Definitions

Introduction

Getting Answers Your Way

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

ON THE INTERNET

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

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

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

BY TELEPHONE

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** ***www.bcbs.com*** 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain surgeries, therapies, diagnostic tests and medical supplies	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday -– Friday
HEALTHLINE SM NURSE ACCESS AND RECORDED TOPICS	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
BEHAVIORAL HEALTHCARE MANAGEMENT	To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	**1-800-626-3643** NON-EMERGENCY CARE 8:30 a.m. to 5:00 p.m. Monday – Friday EMERGENCY CARE 24 hours a day, 7 days a week
EMPIRE PHARMACY MANAGEMENT PROGRAM	Information about the program Locate a participating retail pharmacy Obtain a complete drug formulary list	**1-800-342-9816** TDD for hearing impaired: **1-800-241-6895** 7:00 a.m. to 10:00 p.m. Monday – Friday 9:00 a.m. to 9:00 p.m. Saturday 9:00 a.m. to 5:30 p.m. Sunday
VISION CARE	To find a participating Davis vision care network provider in your area	**1-877-923-2847** 8:00 a.m. to 8:00 p.m. Monday – Friday 9:00 a.m. to 4:00 p.m. Saturday
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

IN WRITING

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

Your Identification Card

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

The information on your card includes your name, identification number, and various co-payment amounts. Below is an example of an Empire ID card.

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

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

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

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

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

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

A: Visit *www.empireblue.com* or call Member Services.

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

Using Your EPO

Know the Basics

USE YOUR EPO TO YOUR BEST ADVANTAGE

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

- BE SURE YOU KNOW WHAT'S COVERED BY THE PLAN. That way, you and your doctor are better able to make decisions about your healthcare. Empire will work with you and your doctor so that you can take advantage of your healthcare options and are aware of limits the plan applies to certain types of care.
- PLEASE REMEMBER TO PRECERTIFY hospital, ambulatory surgery (for medically necessary cosmetic/reconstructive surgery, outpatient transplants, ophthalmological or eye-related procedures) and other facility admissions, maternity care, certain diagnostic tests and procedures, and certain types of equipment and supplies to ensure maximum benefits. Precertification gives you and your doctor an opportunity to learn what the plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.
- ASK QUESTIONS about your healthcare options and coverage. To find answers, you can:
  - Read this Guide.
  - Call Member Services when you have questions about your EPO benefits in general or your benefits for a specific medical service or supply.
  - Call HealthLine℠ Nurse Access and Recorded Topics – available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss healthcare options and more.

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

The key to using your EPO plan is understanding how benefits are paid. To receive benefits, you must use a provider in the Empire network or one covered through the BlueCard PPO Program. There are no out-of-network benefits under this program.

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*.

IN-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 EPO members. With 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 across the country from providers participating in the BlueCard PPO® network through local Blue Cross and Blue Shield plans.
- 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 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 healthcare.
- CONVENIENCE – Usually, there are no claim forms to file.

WHERE TO FIND NETWORK PROVIDERS

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

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

Here's an example of how in-network works.

	IN-NETWORK
PROVIDER'S CHARGE	$500
ALLOWED AMOUNT	$400
PLAN PAYS PROVIDER	$385
YOU PAY PROVIDER	$15
CO-PAYMENT (for office visits and certain covered services)	$15 per visit
CO-PAYMENT (for hospital inpatient admissions)	$0
CO-PAYMENT (for emergency room)	$50 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	$0
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	N/A
LIFETIME MAXIMUM	Unlimited

YOUR EPO BENEFITS OUT-OF-AREA

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

Inside U.S. through the BlueCard® PPO program

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

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

BLUECARD® WORLDWIDE PROGRAM

Outside U.S. (BlueCard® Worldwide Program)

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

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

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

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

Women's Health and Cancer Rights of 1998

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

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

Your Benefits At A Glance

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

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

HOME, OFFICE/OUTPATIENT CARE	YOU PAY
HOME/OFFICE VISITS	$15 co-payment per visit
SPECIALIST VISITS	$15 co-payment per visit
CHIROPRACTIC CARE*	$15 co-payment per visit
SECOND OR THIRD SURGICAL OPINION**	$15 co-payment per visit
DIAGNOSTIC PROCEDURES	
• X-rays and other imaging	$0
• Radium and Radionuclide therapy	$0
• MRIs/MRAs***	$0
• Nuclear cardiology services ***	$0
• PET/CAT scans***	$0
• Laboratory tests	$0
SURGERY	$0

* *It is the provider's responsibility to call Empire to determine medical necessity of all in-network chiropractic care after the fifth visit.*

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

*** *It is the provider's responsibility to call Empire for precertification of all in-network PET/ CAT scans, MRIs/ MRAs and Nuclear Cardiology services.*

HOME, OFFICE/OUTPATIENT CARE	YOU PAY
DIABETES EDUCATION AND MANAGEMENT	$15 co-payment per visit
ALLERGY CARE • **Office Visit** • **Testing** • **Treatment**	 $15 co-payment per visit $0 $0
PRE-SURGICAL TESTING	$0
ANESTHESIA	$0
CHEMOTHERAPY, RADIATION	$0
KIDNEY DIALYSIS	$0
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$15 co-payment per visit
CARDIAC REHABILITATION	$15 co-payment

PREVENTIVE CARE	YOU PAY
ANNUAL PHYSICAL EXAM • One per calendar year	$15 co-payment per visit
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Over age 50-: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age • Diagnostic PSA: 1 per year	$0 $0 $0 $0 $0
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	$15 co-payment per visit $0 $0 $0
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 • Office visits and associated lab services provided within 5 days of office visit – From birth up to age 1: 7 visits – Ages 1 through 4: 6 visits – Ages 5 through 11: 7 visits – Ages 12 up to 19th birthday: 8 visits • Immunizations	$0 $0 $0

**See the Preventive Care section for more details.*

EMERGENCY CARE	YOU PAY
EMERGENCY ROOM	$50 co-payment per visit (waived if admitted to the same hospital within 24 hours)
PHYSICIAN'S OFFICE	$15 co-payment per visit
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	$0
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the allowed amount
MATERNITY CARE AND INFERTILITY TREATMENT	**YOU PAY**
PRENATAL AND POSTNATAL CARE (In doctor's office)	$0
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0
OBSTETRICAL CARE (In hospital)	$0
INFERTILITY TREATMENT	$0
OBSTETRICAL CARE (In birthing center)	$0

HOSPITAL SERVICES*	YOU PAY
SEMIPRIVATE ROOM AND BOARD	$0
ANESTHESIA AND OXYGEN	$0
CHEMOTHERAPY AND RADIATION THERAPY	$0
CARDIAC REHABILITATION	$15 co-payment per outpatient visit
DIAGNOSTIC X-RAYS AND LAB TESTS	$0
DRUGS AND DRESSINGS	$0
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0
INTENSIVE CARE	$0
KIDNEY DIALYSIS	$0
PRESURGICAL TESTING	$0
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0
SURGERY (Inpatient and outpatient)**	$0

* *Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation. See the Coverage section for a description of these benefits. Outpatient hospital surgery and inpatient admissions need to be precertified.*

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

DURABLE MEDICAL EQUIPMENT AND SUPPLIES	YOU PAY
DURABLE MEDICAL EQUIPMENT (i.e., hospital-type bed, wheelchair, sleep apnea monitor)	$0
ORTHOTICS	$0
PROSTHETICS (i.e., artificial arms, legs, eyes, ears)	$0
MEDICAL SUPPLIES (i.e., catheters, oxygen, syringes)	$0
NUTRITIONAL SUPPLEMENTS* (enteral formulas and modified solid food products)	$0
SKILLED NURSING AND HOSPICE CARE	**YOU PAY**
SKILLED NURSING FACILITY • Up to 60 days per calendar year	$0
HOSPICE • Up to 210 days per lifetime	$0
HOME HEALTH CARE	
• Up to 200 visits per calendar year (a visit equals 4 hours of care)	$0
• Home infusion therapy	$0
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**YOU PAY**
PHYSICAL THERAPY AND REHABILITATION • Up to 30 days of inpatient service per calendar year	$0
• Up to 30 visits combined in home, office or outpatient facility per calendar year	$15 co-payment per visit
OCCUPATIONAL, SPEECH, VISION THERAPY** • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$15 co-payment per visit

* *$2,500 limit for modified solid food products in any continuous 12-month period.*

** *Vision therapy does not require precertification.*

MENTAL HEALTH CARE	YOU PAY
OUTPATIENT  • Up to 20 visits per calendar year	$25 co-payment per visit
INPATIENT  • Up to 30 days per calendar year • Up to 30 visits from mental health care professionals per calendar year	$0 $0
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**YOU PAY**
OUTPATIENT  • Up to 60 visits per calendar year, including up to 20 visits for family counseling	$0
INPATIENT  • Up to 7 days detoxification per calendar year	$0
PHARMACY (RETAIL AND MAIL ORDER)	**YOU PAY**
RETAIL • Generic • Brand • Non-Formulary **MAIL ORDER** • Generic • Brand • Non-Formulary	 $10 co-payment per 30 day supply $20 co-payment per 30 day supply $40 co-payment per 30 day supply $20 co-payment per 90 day supply $40 co-payment per 90 day supply $80 co-payment per 90 day supply
(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.)	
VISION [2]	**YOU PAY**
EYE EXAM • One eye exam every 24 months	$5 co-payment per visit
FRAMES	$10 co-payment per pair
LENSES (single vision, bifocal or trifocal)	$0
SOFT CONTACT LENSES	$10 co-payment per pair
Davis Vision Non-Plan Frames	$25 allowance
Davis Vision Non-Plan Contact Lenses	$75 allowance

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

Coverage

Doctor's Services

When you need to visit your doctor or a specialist, Empire makes it easy. By staying 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.

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, visit *www.empireblue.com* or 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 any time that you are unsure about surgery or a cancer diagnosis. Second and third opinions for surgery are paid in full when arranged through Empire's Medical Management Program. The specialist who provides the second or third opinion cannot perform the surgery. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid at the in-network level, even if you use an out-of-network specialist, as long as your participating doctor provides a written referral to a non-participating specialist.

What's Covered

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

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

What's Not Covered

The following medical services are not covered:

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

Emergency Care

IF YOU NEED EMERGENCY CARE

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

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

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

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's 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 I.D. card when you arrive at the emergency room.

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

Tips For Getting Emergency Care

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

What's Not Covered

These emergency services are not covered:

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

Emergency Air Ambulance

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

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

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

Benefits must be authorized by Empire's Medical Management program before services are rendered, or within forty eight (48) hours after a Covered Person is admitted to or treated at the hospital, or as soon as reasonably possible. Failure to obtain authorization from Empire within the required time will result in a penalty of 50% of benefits otherwise available.

Remember to call Empire's Medical Management Program at 1-800-982-8089 for prior authorization or within 48 hours after services to receive benefits for air ambulance and to avoid the 50% penalty.

Emergency Land Ambulance

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

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

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

Maternity Care and Infertility Treatment

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.

Remember to call Empire's Medical Management Program at 1-800-982-8089 within the first three months of a pregnancy. This will ensure that you receive maximum benefits.

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

MATERNITY CARE PROGRAM

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

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

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

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

What's Covered

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

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

What's Not Covered

These maternity care services are not covered:

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

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

INFERTILITY TREATMENT

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

What's Covered

Medical and surgical procedures, such as

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

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

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

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

What's Not Covered

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

- In-vitro fertilization
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Reversal of elective sterilizations, including vasectomies and tubal ligations
- Sex-change procedures
- Cloning
- Medical or surgical services or procedures that are experimental
- Services to diagnose or treat infertility if we determine, in our sole judgment, that the service was not medically necessary.

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

Hospital Services

IF YOU VISIT THE HOSPITAL

Your plan covers most of the cost of your medically necessary care when you stay at a network hospital for surgery or treatment of illness or injury. No benefits are available when you use an out-of-network provider.

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

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

Remember to call Empire's Medical Management Program at 1-800-982-8089 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission or emergency surgical procedure, call Medical Management within 48 hours or as soon as reasonably possible. Otherwise your benefits may be reduced by 50% up to $5,000 for each hospital admission or surgery that is not precertified. Benefit reductions will also apply to all care related to the admission, including physician services.

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

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

When you use a network hospital, you will not need to file a claim in most cases.

Tips For Getting Hospital Care

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

Inpatient And Outpatient Hospital Care

What's Covered

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

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

Inpatient Hospital Care

What's Covered

Following are additional covered services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician, and
  - A hospital stay is medically necessary.

  Coverage is for unlimited days, subject to Empire's Medical Management Program review, unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery

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

  The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.
- Use of cardiographic equipment
- Drugs, dressings and other medically necessary supplies
- Social, psychological and pastoral services
- Reconstructive surgery associated with injuries unrelated to cosmetic surgery
- Reconstructive surgery for a functional defect which is present from birth
- Physical, occupational, speech and vision therapy including facilities, services, supplies and equipment
- Facilities, services, supplies and equipment related to medically necessary medical care

Outpatient Hospital Care

What's Covered

Following are additional covered services for same-day care:

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

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

- Private duty nursing
- Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room.
- 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 EPO covers the cost of medically necessary prosthetics, orthotics and durable medical equipment and medical supplies from network suppliers only. Out-of-network benefits are not available. Benefits and plan maximums are shown in Your *Benefits At A Glance* section.

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

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

Tip For Obtaining Special Medical Supplies

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

What's Covered

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

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

What's Not Covered

The following equipment is not covered:

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

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

You receive coverage through Empire's EPO for inpatient care in a skilled nursing facility or hospice. Benefits are available for network facilities only.

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

Skilled Nursing Care

What's Covered

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

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

What's Not Covered

The following skilled nursing care services are not covered:

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

Hospice Care

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

What's Covered

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

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

Tips for Receiving Skilled Nursing and Hospice Care

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

Home Health Care

IF YOU NEED HOME HEALTH CARE

Home health care can be an alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive coverage for home health care and home infusion therapy when you use an in-network provider. Benefits and plan maximums are shown in Your *Benefits At A Glance* section

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

What's Covered

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

- Up to 200 home health care visits per year. 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 EPO for outpatient physical, occupational, speech and vision therapy by a network provider. There are no benefits for out-of-network services.

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

Tip for Receiving Therapy

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

What's Covered

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

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

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

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

What's Not Covered

The following therapy services are not covered:

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

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

At Empire we realize that your mental health is as important as your physical health. That's why we include behavioral health benefits at little out-of-pocket cost. Your behavioral healthcare benefits cover outpatient treatment for alcohol or substance abuse, inpatient detoxification, and inpatient and outpatient mental health care from network providers only. You will not receive benefits for any of these services if you go out-of-network.

To help ensure that you receive appropriate care, you need to precertify all behavioral healthcare services in advance. When you call the Behavioral Healthcare Management Program at 1-800-626-3643 to precertify in-network services, a counselor will refer you to an appropriate hospital, facility or provider and send written confirmation of the authorized services.

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

- 50% up to $5,000 per inpatient admission for mental health or alcohol/substance abuse detoxification
- 50% for each outpatient mental health visit
- 50% for each outpatient alcohol and substance abuse facility or provider visit
- 50% for each professional mental health care visit made during an inpatient stay

REMEMBER	**When you are admitted in an emergency to a hospital or other inpatient facility for behavioral health problems, you or someone on your behalf must call the Behavioral Healthcare Management Program at 1-800-626-3643 within 48 hours or as soon as is reasonably possible.** **If you want to know if a provider or facility is covered in-network, call the Behavioral Healthcare Management Program.** **If you do not agree with a certification decision made by the Behavioral Healthcare Management Program, you can file an appeal. For more information see "Appeals and Grievances" in the Details and Definitions section.**

Mental Health Care

What's Covered

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

- Electroconvulsive therapy for treatment of mental or behavioral disorders, if precertified by Behavioral Healthcare Management
- Care from psychiatrists, psychologists or licensed clinical social workers, providing psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders. Social workers must be licensed by the New York State Education Department or a comparable organization in another state, and have three years of post-degree supervised experience in psychotherapy and an additional three years of post-licensure supervised experience in psychotherapy.
- Treatment in a comprehensive care center for eating disorders.

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 for alcohol or substance abuse 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.

What's Not Covered

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

- Care that is not medically necessary
- Inpatient alcohol and substance abuse rehabilitation

Empire Pharmacy Management℠

YOUR PHARMACY BENEFITS PROGRAM

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

FILLING A PRESCRIPTION

You pay a co-payment each time you fill your prescription at a network pharmacy. Co-payments vary depending on whether the prescription is for a generic, brand-name formulary or non-formulary drug. Using generic medicines, where appropriate, will help you to maximize your benefits.

EMPIRE'S DRUG FORMULARY

Empire's Drug Formulary is a list of covered prescription drugs recommended for use by Empire's providers. It includes generic and certain covered brand-name drugs. You will pay a higher co-payment for brand-name formulary and non-formulary drugs, and realize the most savings for generic drugs.

You can get an up-to-date formulary by visiting *www.empireblue.com* or calling Member Services 1-800-342-9816. Member Services can also provide information about Empire's procedures and pharmaceutical decisions.

Certain drugs require prior authorization. They are identified as "PAR" (Prior Authorization Required) and must be approved by Empire before you fill the prescription. Your physician or pharmacist can request this authorization by calling Empire Pharmacy Services at 1-800-342-9816. Some drugs have quantity limits. They are indicated by the letters "QL" (Quantity Limit) and require authorization only if a prescription is written for more than the monthly allowed amount. Some of the drugs requiring any of these actions are noted on the formulary list. If the quantity is approved, it will be covered.

Some drugs must be specially ordered. In order for certain specialty injectable medications to be covered under Empire's pharmacy plan, prescriptions must be filled by Caremark (formerly known as AdvancePCS) SpecialtyRx. Those particular medications are listed with the symbol SRx next to them. For further information regarding filling a prescription for specialty injectable medications with Caremark Specialty Rx, call 1-866-295-2779, Monday – Friday, 8:00 a.m. to 6:00 p.m. EST.

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

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

NETWORK PHARMACY

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

- **Low cost**. You can receive up to a 30-day supply for each drug for a single co-payment.
- **Convenience**. You must present your Empire ID card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program.
- **No claim forms!** Under your policy guidelines, paper claims cannot be submitted. The pharmacist must submit your claim when you fill the prescription.

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.

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

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

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

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

How to Order Your Prescription by Mail

- Ask your doctor to write a prescription for each of your medication(s) 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.)
- The first time you fill a prescription through mail order, ask your physician for a second prescription for a three-week supply. You can fill the second prescription at a local pharmacy so you have the medication until the mail order is processed.
- Complete the mail order form you received in the mail with your ID card(s). You can get additional forms by going to *www.empireblue.com* or calling Empire Pharmacy Management at the number on the back of your member ID card.
- Place your order for a refill at least three weeks before your current supply will run out.

You will receive your filled prescription at your home within 14 working days, postage paid. If you prefer, you can also choose faster shipping for an additional fee.

MANAGE YOUR PHARMACY PLAN ONLINE

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

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

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

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

What's Covered

The following prescription drugs are covered:

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

What's Not Covered

The following items are not covered:

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

Vision Care

IF YOU NEED VISION CARE

Empire recognizes that good vision is part of good health, so we offer vision care coverage. To find a Davis Vision network provider in your area, simply call 1-877-923-2847 between 8:00 a.m. and 8:00 p.m. weekdays, 9:00 a.m. and 4:00 p.m. Saturdays. Then contact the provider to make an appointment. You pay lower co-payments when you use a Davis Vision network provider.

VISION CARE SERVICES	CO-PAYMENT
EYE EXAM	$5
FRAMES	$10
SINGLE VISION, BIFOCAL OR TRIFOCAL LENSES	$0
SOFT CONTACT LENSES – (one pair daily or disposable)	$10
FASHION FRAMES	$0
DESIGNER FRAMES	$15
PREMIER FRAMES	$25
STANDARD PROGRESSIVE ADDITION LENSES	$50
PREMIUM PROGRESSIVE ADDITION LENSES	$90
BLENDED SEGMENT LENSES	$20
PHOTOCHROMIC OR SUPERSHIELD SINGLE VISION LENSES	$20
PHOTOCHROMIC OR SUPERSHIELD MULTIFOCAL VISION LENSES	$20
ULTRAVIOLET COATING	$12
REFLECTION-FREE COATING	$35
PREMIUM REFLECTION-FREE COATING	$48
POLAROID LENSES	$75
POLYCARBONATE LENSES	$30
HIGH INDEX LENSES	$55
TRANSITION LENSES	$65
INTERMEDIATE VISION LENSES	$30
NON-PLAN ALLOWANCES	**ALLOWANCE**
DAVIS VISION NON-PLAN FRAMES	$25
DAVIS VISION NON-PLAN CONTACT LENS	$75

ALLOWANCES FROM NON-DAVIS PROVIDERS	ALLOWANCE
EYE EXAM	$30
FRAMES	$30
SINGLE VISION	$25
BIFOCAL	$35
TRIFOCAL	$45
CONTACT LENSES	$75

What's Covered

Vision care benefits include one comprehensive eye exam, subject to a $5 co-payment if you use a Davis Vision Network Provider or a $30 allowance for Non Davis Vision Providers and a select group of eyewear (frames with corrective lenses or contact lenses) every 24 months for each covered member. Eye exams must be conducted in a single visit. If you purchase eyewear, you must buy it from the same Network Provider who did the examination.

What's Not Covered

The following vision care services are not covered:

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

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:

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

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

Government Services

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

Home Care

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

Inappropriate Billing

- Services usually given without charge, even if charges are billed

- Services performed by hospital or institutional staff which are billed separately from other hospital or institutional services, except as specified

Medically Unnecessary Services

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

Miscellaneous

- Surgery and/or treatment for gender change

Prescription Drugs

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

Sterilization/Reproductive Technologies

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

Travel

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

War

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

Workers' Compensation

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

LIMITATION AS INDEPENDENT CONTRACTOR

The relationship between Empire 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 BlueCross will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

Health Management

HELPING YOU MANAGE YOUR HEALTH

Managing your health includes getting the information you need to make informed decisions, and making sure you get the maximum benefits the plan will pay. To help you manage your health, Empire provides three important services: Medical Management, Case Management and HealthLine℠ Nurse Access.

Empire's Medical Management Program

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

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

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

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

- Review planned and emergency hospital admissions
- Review ongoing hospitalization
- Review inpatient and same-day surgery
- Review high risk pregnancies
- Review routine maternity admissions
- Perform individual case management
- Review care in a skilled nursing facility
- Coordinate discharge planning

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

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

CALL TO PRECERTIFY …	HOW COVERED	WHO CALLS TO PRECERTIFY
ALL HOSPITAL ADMISSIONS • At least two weeks prior to any planned surgery or hospital admission • Within 48 hours of an emergency hospital admission, or as soon as reasonably possible • For illness or injury to newborns	Empire and BlueCard PPO network	YOU
PREGNANCY • Within the first three months of a pregnancy	Empire and BlueCard PPO network	YOU
BEFORE YOU RECEIVE • Inpatient physical therapy • Same-day surgery for medically necessary cosmetic/ reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures • Occupational or speech therapy • Outpatient physical therapy • Skilled nursing facility care • Air ambulance service	Empire and BlueCard PPO network	YOU
BEFORE YOU • Rent, purchase or replace prosthetics, orthotics or durable medical equipment	Empire network	NETWORK SUPPLIER
	BlueCard PPO network	YOU
BEFORE YOU RECEIVE • Chiropractic care* • MRIs/MRAs** • Nuclear cardiology services ** • PET/CAT scans**	Empire network	PROVIDER
	BlueCard PPO network	NO PRECERTIFICATION REQUIRED

* It is the provider's responsibility to call Empire to determine medical necessity of all in-network chiropractic care after the fifth visit.

** It is the provider's responsibility to call Empire for precertification of all in-network PET/ CAT scans, MRIs/ MRAs and Nuclear Cardiology services. Penalties will apply if precertification is not obtained.

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

IF SERVICES ARE NOT PRECERTIFIED

If you call to precertify services as needed, you will receive maximum benefits. Otherwise, benefits may be reduced by 50% up to $5,000 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.

Tips for Precertifying Services with Medical Management

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

Initial Decisions

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

- *Precertification Requests*. Precertification means that you must contact Empire's Medical Management Program for approval before you receive certain health care services. We will review all requests for precertification within three (3) business days of receipt of the necessary information but not to exceed 15 calendar days from the receipt of the request. If we do not have enough information to make a decision within three (3) business days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within three (3) business days of our receipt of the requested information, or if no response is received, within three (3) business days after the deadline for a response.
- *Urgent Precertification Requests*. If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- *Concurrent Requests.* Concurrent review means that Empire reviews your care during your treatment to be sure you get the right care in the right setting and for the right length of time. We will complete all concurrent reviews of services within 24 hours of our receipt of the request.
- *Retrospective Requests.* Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, we will notify you in writing of the additional information we need, and you and your provider will have 45 calendar days to respond. We will make a decision within 15 calendar days of our receipt of the requested information, or if no response is received, within 15 calendar days after the deadline for a response.

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

IF A REQUEST IS DENIED

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

If Empire's Medical Management Program denies benefits for care 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 the EPO 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.

Healthy Living Programs

PREVENTIVE CARE

Preventive care is an important and valuable part of your healthcare. Regular physical check-ups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why Empire provides many preventive care services for free or only a small co-payment when you use network providers. No benefits are available when you use an out-of-network provider.

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

Tips For Using Preventive Care

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

What's Covered

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

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

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

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

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

What's Not Covered

These preventive care services are not covered:

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

360° Health® – Empire's Health Services Programs

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

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

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

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

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

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

You can also access an easy-to-use audio library. You'll hear advice and news delivered in English and Spanish on more than 1,100 topics — from colds and sore throats to diabetes and cancer. Please refer to the back of this book for a list of recorded topics.

HealthLine is not for emergencies, so please do not call if you believe you or a family member

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

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

Here's how to use HealthLine:

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

Empire Healthy Discounts – Members can receive discounts on alternative medicine therapies and other health services. Go to the "Members" section of *www.empireblue.com*, look under "Empire's Plans" and click on your plan name. You can get access to discounts, services and products such as:

Alternative Practitioners – Receive discounts on services from hundreds of chiropractors, acupuncturists, massage therapists and nutritional counselors participating in alternative healthcare programs administered by American Specialty Health Networks™ (ASH Networks) — all without a doctor's referral. Search ASH Network's online directory at *www.healthyroads.com* and show your member ID at your office visit to quality for the discount.

Wellness Products – Members receive discounts of up to 40% on thousands of quality health and wellness products: vitamins, herbal supplements, homeopathic remedies, sports nutrition products, health-related books and videos and more. You may purchase products by visiting *www.healthyroads.com* or by calling 1-888-289-4325.

Vision Services – Save up to 25% on laser vision correction, as well as up to 75% on vision care with Davis Vision, including complete eye exams, lenses, frames, and mail-order contact lens replacement. You can locate a network provider at *www.davisvision.com* or call 1-877-92-DAVIS (1-877-923-2847). Simply present your Empire member ID at the time of your appointment. Discounted vision services are available only to Empire members who are not covered by a Davis Vision care benefits rider to their health plan. If you are covered by a Davis Vision care benefits rider, then many of these discounts are actively covered benefits under your plan. Call the number on the back of your member ID card to verify your vision coverage.

Fitness Club Membership – Save on membership fees and receive a free one-week membership with any of the thousands of facilities in the International Fitness Club Network (IFCN). You can even get discounts on home fitness equipment. To find a club near you and printout savings certificates, visit *www.ifcn.org* or call 1-800-866-8466.

Weight Loss Programs – Get free registration at your participating local New York or New Jersey Weight Watchers®[1] location. Just show your Empire member ID card upon registering. For more information or to find a location near you, visit *www.weightwatchers.com* or call 1-800-651-6000.

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

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

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

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

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

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

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

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

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

Details and Definitions

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

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

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

Eligibility

WHEN ARE YOU ELIGIBLE?

Your coverage under Empire's plan begins on:

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

Contact your Benefits Administrator for more information on eligibility rules.

ELIGIBLE DEPENDENTS

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

- Your spouse
- Your unmarried children (including stepchildren)
  - Until the end of the calendar year in which each child reaches age 23, or
  - Until the end of the calendar year in which each child reaches age 25, as long as the child remains unmarried, is dependent on you, and is a registered full-time student at an accredited college or university (a dependent's full-time attendance at an accredited school of higher education must be documented annually), or
  - Until the child is no longer dependent on you or your spouse, or
  - Until the date of his or her marriage; whichever is earliest
- Your unmarried children, regardless of age, who are physically or mentally disabled as defined by New York Mental Hygiene Law, provided the condition started before the age when coverage would have normally ended. Empire will require that a physician certify the child's condition.

Your EPO does not cover foster children.

COVERAGE CATEGORY

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

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

ADDING OR REMOVING A DEPENDENT

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

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

If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the group's open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within 30 days after the qualifying event.

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

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

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

- Contract holder contributions toward the premium payments for the other plan were terminated

Coverage must be applied for within 30 days of termination for one of the reasons described above.

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

A newborn natural baby or an adopted baby in certain circumstances (see below) will automatically be covered under the plan if you have family coverage. However, you will need to add the baby's name as a covered dependent. If you do not have two-person or family coverage but notify Empire in writing within 30 days to change to two-person or family coverage, Empire will provide retroactive coverage during this period. Otherwise, coverage will begin on the date Empire receives your notice of election form from your employer during the open enrollment period.

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

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

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

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

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

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

A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not an employee.

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

Claims

IF YOU NEED TO FILE A CLAIM

Empire's EPO 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, as the provider files the claim directly with Empire or the local Blue Cross/Blue Shield plan. However, you will have to file a claim for reimbursement for covered services if you have a medical emergency and obtain emergency services from a non-participating provider. To obtain a claim form, call customer service.

Send completed forms to:

Hospital Claims:

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

Medical Claims:

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

Tips for Filing a Claim

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

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 anytime of day or night just by visiting *www.empireblue.com.*

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

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

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

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

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

Which Plan Pays Benefits First?

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

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.
  - If the parent with custody is remarried, his or her plan pays first, the step-parent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.

- If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire Is the Secondary Plan

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

Tips for Coordinating Benefits

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

If You Receive An Overpayment Of Benefits

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

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

SUBROGATION

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

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

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

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

If you fail to cooperate with us in an action we bring against the party responsible for your illness or injury to recover the benefits we have paid or provided, the following penalty will apply: You will be responsible to repay to us the amount of the benefits we have paid or provided. We agree to invoke this penalty only when your illness or injury caused by the third party results in our expenditure on your behalf of an amount exceeding $500 under this coverage.

Health Care Fraud

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

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

If You Have Questions About a Benefit Payment

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

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

The notification will give you:

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

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

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

Complaints, Appeals and Grievances

COMPLAINTS

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

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

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

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

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

Provider Quality Assurance

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

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

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

Your Right to Appoint a Representative

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

STANDARD INTERNAL APPEALS

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

Appeals may be filed by telephone or in writing.

Level 1 Appeals

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

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

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

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

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

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

If Empire's Medical Management Program does not make a decision within 60 calendar days of receiving all necessary information to review your appeal, Empire will approve the service.

If you are dissatisfied with the outcome of your Level 1 Appeal, you have the right to file a Level 2 Appeal, and/or the right to file an External Appeal through the New York State Department of Insurance.

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

Expedited Level 1 Appeals

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

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

Expedited Appeals may be filed by telephone and in writing.

Please note that appeals of claims decisions made after the service has been provided cannot be expedited. When you file an expedited appeal, Empire will respond as quickly as possible given the medical circumstances of the case, subject to the following maximum timeframes:

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

If you are dissatisfied with the outcome of your Level 1 Expedited Appeal, you may request an external review by a New York State Department of Insurance appeals agent. For more details see the explanation of External Appeals.

If Empire's Medical Management Program does not make a decision within 2 business days of receiving all necessary information to review your appeal, Empire will approve the service.

Level 2 Appeals and Timeframes

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

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

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

EXTERNAL APPEALS

As an alternative to filing a Level 2 Appeal with Empire, you may request an external review by a New York State Department of Insurance appeals agent. You can file an external appeal if benefits were denied:

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

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

To Obtain An External Appeal

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

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

Resolving an External Appeal

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

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

Submit your appeal within 45 calendar days:

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

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

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

Standard External Review Process

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

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

Expedited External Appeals

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

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

LEVEL 1 GRIEVANCES

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

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

If the services have already been provided, Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance. The written acknowledgement will include the name, address, and telephone number of the department that will respond to the grievance, and a description of any additional information required to complete the review.

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

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

LEVEL 2 GRIEVANCES

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

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

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

EXPEDITED GRIEVANCES

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

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

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

DECISION ON GRIEVANCES

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

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

HOW TO FILE AN APPEAL OR GRIEVANCE

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

The address for filing an appeal or grievance is:

Empire BlueCross
Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Ending and Continuing Coverage

WHEN COVERAGE ENDS

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

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

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

Notice of Qualifying Events:

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

For the other qualifying events, (your divorce or legal separation, or a dependent child's losing eligibility for coverage as a dependent child), you must notify your Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the GBA, Niskayuna Central School District Title Or Category And Company Name.

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Kathy Smith, GBA, [enter name and/or title of party responsible for COBRA administration] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

DISABILITY

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

SECOND QUALIFYING EVENT

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

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

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

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

FOR MORE INFORMATION

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

If you have any questions concerning the information in this notice or your rights to coverage, you should contact Kathy Smith, GBA, Niskayuna Central School District, 1239 Van Antwerp Road, Niskayuna, New York 12309, 518-377-4666. [enter name and/or title of party responsible for COBRA administration for the Plan, with telephone number and address].

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

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

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

THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

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

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

RESERVISTS SUPPLEMENTARY CONTINUATION AND CONVERSION

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

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

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

CONVERTING YOUR COVERAGE

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

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

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

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

To convert your coverage, you must:

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

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

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

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

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

ENDING AND CONTINUING COVERAGE

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

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

PORTABILITY OF COVERAGE

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

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

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

IF YOU BECOME DISABLED

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

Coverage will end when the disabled person:

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

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

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

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

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

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

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

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

This limitation applies even if you or your spouse fail to enroll in Medicare or do not claim the benefits available under Medicare.

CARVE-OUT PROGRAM

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

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

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

Your ERISA Rights

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

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

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

Duties of the Plan Fiduciaries

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

Steps You Can Take to Enforce Your Rights

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

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

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

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

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

Confidentiality Policy

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

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

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

Please refer to the Notice of Privacy Practices section for more information.

ACCESS TO INFORMATION

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

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

For Members Who Don't Speak English

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

Notice of Privacy Practices

EFFECTIVE DATE: APRIL 14, 2003
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

At Empire, we respect the confidentiality of your medical information and will protect that information in a responsible manner. We have a comprehensive privacy program in place that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, the government legislation that sets standards for the privacy of medical information. Empire follows all state privacy laws to which we are subject that do not conflict with the HIPAA Privacy Regulations. However, if a state privacy law conflicts with the HIPAA Privacy Regulations yet provides greater privacy rights or protections than the HIPAA Privacy Regulations, we will follow that state law.

We must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the changes are permitted by law. Before we make a significant change to our privacy practices, we will change this notice and send the new one to our current subscribers. This new notice will be effective for all medical information that we maintain, including medical information we created or received before the changes were made.

Additionally, please know that Empire is required by law to maintain the privacy of your medical information and to give you this notice regarding your rights, our privacy practices and legal duties concerning your medical information.

DEFINITION OF MEDICAL INFORMATION

When Empire refers to medical information in this notice, we mean information that is individually identifiable health information. This includes demographic information collected from you or created or received by a healthcare provider, a health plan, your employer or a healthcare clearinghouse.

This information relates to:

(1) Your past, present or future physical or mental health or condition
(2) The provision of health care to you, or
(3) Past, present or future payments for the provision of healthcare to you.

USES AND DISCLOSURES OF MEDICAL INFORMATION

This section provides you with a general description and examples of the ways your medical information is used and disclosed. Empire's uses and disclosures are not limited to these examples.

Treatment

Your medical information may be used or disclosed to a physician or other healthcare provider in order for them to provide you with treatment.

Payments

Your medical information may be used or disclosed:

- For billing, claims management and collections activities
- To pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan
- To determine your eligibility for benefits
- To conduct risk adjustment activities
- To coordinate benefits
- To determine medical necessity
- To conduct utilization review activities
- To obtain premiums
- To issue explanations of benefits to the person who subscribes to the health plan in which you participate
- To a health care provider or entity so they can obtain payment or engage in payment activities

Health Care Operations

Your medical information may be used and disclosed in connection with our healthcare operations, including:

- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of benefit coverage.
- Case management and care coordination.
- Contacting healthcare providers and patients with information about treatment alternatives, disease management or wellness programs and related functions that do not include treatment.
- Population-based activities relating to improving health or reducing health care costs.
- Quality assessment and improvement activities and protocol development.
- Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Conducting or arranging for medical review, legal services, auditing, and fraud and abuse detection and compliance programs.
- Business planning and development, such as formulary development and administration.
- Business management and general administrative activities, including management activities relating to privacy, customer service and resolution of internal grievances.

Additional Disclosures

Your medical information may be disclosed:

- To another entity that has a relationship with you for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.
- To other persons or entities that assist us in conducting our payment, health care operations and business activities. We will not disclose your medical information to those persons or entities unless they agree to keep it protected.

Health-Related Services

Your medical information may be used to send you appointment reminders, or to communicate with you to encourage you to purchase or use a health-related product or service (or payment for such product or service), that is provided by, or included in, an Empire health plan.

This includes communications about: the entities participating in a healthcare provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a benefit plan, for purposes of treatment, case management or care coordination, or to direct or recommend alternative treatments, therapies, healthcare providers or settings of care.

To Your Family and Friends

Your medical information may be disclosed to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Your name, location and general condition or death may be used or disclosed to notify or assist in the notification of (including identifying or locating) a person involved in your care.

We will provide you with an opportunity to object to such uses or disclosures, unless, based on professional judgment, we may reasonably infer from the circumstances that you do not object to such uses and disclosures.

If you are not present, or in the event of your incapacity or an emergency, we will use our professional judgment in deciding whether disclosing your medical information would be in your best interest.

If You Are a Member of a Group Health Plan

Your medical information, and the medical information of others enrolled in your group health plan, may be disclosed to your employer or the organization that sponsors your group health plan (the "plan sponsor") in order to permit the plan sponsor to perform plan administration functions. Please see your plan documents for an explanation of these limited uses and disclosures.

Summary information about the enrollees in your group health plan may also be disclosed to the plan sponsor so they may obtain premium bids for health insurance coverage, or in order to decide whether to modify, amend or terminate your group health plan. The information we may disclose summarizes claims history and expenses or types of claims experienced by the enrollees in your group health plan. This summary information will be stripped of demographic information, but the plan sponsor may still be able to identify you or other enrollees.

Disaster Relief

We may use or disclose your medical information to a public or private entity authorized by its charter or by law to assist in disaster relief efforts.

For the Public Benefit

Your medical information may be used or disclosed as authorized by law for the following purposes:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight and to employers regarding work-related illness or injury
- To report adult abuse, neglect or domestic violence
- To health oversight agencies
- In response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person
- To coroners, medical examiners and funeral directors
- To organ procurement organizations
- To avert a serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state workers' compensation law

Marketing

Your medical information may be used or disclosed to encourage you to purchase or use a product or service by face-to-face communication by us or for us to provide you with promotional gifts of nominal value.

Fundraising

Your demographic information and the dates of healthcare services provided to you may be used in order to contact you for fundraising. We may disclose information to a business associate or foundation to assist us in our fundraising activities. We will provide you with fundraising materials and a description of how you may opt out of receiving future fundraising communications.

Your Written Authorization Is Required

Other uses and disclosures of your medical information that are not described above will only be made with your written authorization. You may give us written authorization to use or to disclose your medical information to anyone for any purpose.

You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure that you permitted prior to your revocation.

Your Individual Rights

Access to Your Information: You have the right to inspect or obtain a copy of the medical information about you that is contained in a "designated record set" except for psychotherapy notes and certain other information. A "designated record set" generally contains medical and billing records as well as other records that are maintained by or for us, or used by or for us to make decisions about you. We may ask you to submit your request in writing and to provide us with the specific information we need in order to fulfill your request. We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies to you. In certain situations, we may deny your request to inspect or obtain a copy of the requested information. If we deny your request, we will notify you in writing and may provide you with an opportunity to have the denial reviewed.

Accounting Disclosures

You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations or those authorized by you as well as for certain other activities that occurred up to six years before the date of your request. However, you will not be able to obtain a list of disclosure instances that occurred prior to April 14, 2003; the date this notice is effective. Any list we send you will include the date(s) of the disclosure, to whom it was made, their address, if known, a brief description of the information disclosed and the purpose of the disclosure. If you request this accounting list more than once in a 12-month period, we may charge you a reasonable administration fee for these additional requests.

Restrictions on Use or Disclosure

You have the right to request that we restrict the use or disclosure of your medical information in connection with treatment, payment and health care operations. You also have the right to request that we restrict disclosures to persons involved in your health care or payment for your health care. We may ask you to submit your request in writing. We will review your request, but we are not required to comply with it.

Confidential Communications

You have the right to request that we communicate with you about your medical information by a different means or location. You must make your request in writing and state that the information could endanger you if it is not communicated by a different means or location. We must accommodate your request if it is reasonable and specifies the new means or location of contact. It must also allow us to collect premiums and pay claims. This includes issuing explanations of benefits to the subscriber of the health plan in which you participate.

An explanation of benefits issued to the subscriber about the subscriber or others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though we communicated with you in the confidential manner you requested. Once your request for confidential communications is in effect, all of your medical information will be communicated in accordance with your instructions.

Amending Your Medical Information

If you believe that the medical information contained in your "designated record set" is not correct or complete, you have the right to request that we amend it. We may require your request be in writing and that it explains why the information should be changed. If we make the amendment, we will notify you. In addition, if we make the change, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

If your request is denied, you will be notified in writing of the reason for the denial and the letter will explain how to file a written statement of disagreement. Empire has the option to rebut your statement. You have the right to ask that your original request, our denial and your statement of disagreement be included with any future disclosures of your information.

Additional Copies, Questions or Complaints

Requests for Additional Copies and Questions Regarding Privacy and Individual Rights:

- You may request a copy of our notice at any time.
- If you view this notice on our website or receive it by e-mail, you are also entitled to receive it in written form.
- You may request more detailed information about your rights and privacy protections or learn how to exercise those individual rights as described in this notice.

Please contact Member Services at the phone number listed on the back of your member identification card or write to us at P.O. Box 1407, Church Street Station, New York, NY 10008-1407.

Complaints

If you believe that Empire has violated your privacy rights, write to our Privacy Office at P.O. Box 1407, Church Street Station, New York, NY 10008-1407 or call Member Services at the phone number listed on the back of your member identification card.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will provide you with this address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. We support your right to the privacy of your medical information.

HIPAA Privacy Requirements

EMPLOYER/SPONSOR

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

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

EMPLOYER/SPONSOR OBLIGATIONS

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

Purpose of Disclosure to Employer/Sponsor

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

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

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

Restrictions on Plan Sponsor's Use and Disclosure of PHI

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

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

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

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

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

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

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

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

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

(j) The Employer/Sponsor will, if feasible, return or destroy all member PHI, in whatever form or medium (including in any electronic medium under the Employer's/ Sponsor's custody or control), received from the Plan that the

---

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

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

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

Adequate Separation between the Employer/Sponsor and the Plan

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

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

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

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

Definitions

Refer to these definitions to help you better understand your Empire EPO 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.

Ambulatory Surgery

See "same-day surgery."

Authorized Services

See "precertified services."

BlueCard® PPO Program

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

BlueCard® Worldwide Program

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

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

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's EPO covers one in-network annual physical exam.

Hospital/Facility

A fully licensed acute-care general facility that has all of the following on its own premises:

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

For pregnancy and childbirth services, the definition of "hospital" includes any birthing center that has a participation agreement with either Empire 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's EPO does not recognize the following facilities as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or mental health care.

In-Network Benefits

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

In-Network Provider/Supplier

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

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

Itemized Bill

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

Medically Necessary

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

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

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

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's EPO 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 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 network
- Is in the PPO network of another Blue Cross and/or Blue Shield plan
- Has a negotiated rate arrangement with another Blue Cross and/or Blue Shield plan that does not have a PPO network

Plan Administrator

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

Precertified Services

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

Provider

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

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

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

Same-Day Surgery

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

Treatment Maximums

Maximum number of treatments or visits for certain conditions.

HealthLine Recorded 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 HealthLine at 1-877-TALK-2RN (825-5276). See the Health Management section for more information on HealthLine and instructions on how to listen to the tapes. These are our most requested audiotapes; there are more than 1,100 available. If you do not see the topic that interests you, just ask one of the HealthLine nurses.

Aging

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

Alcohol Problems

4131 Alcoholism – Causes
4133 Alcoholism - The Disease of Denial

Arthritis

4172 Arthritis Or Rheumatism?
4171 Arthritis Symptoms
4175 Osteoarthritis

Back and Neck

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

Blood and Circulatory

4211 Anemia
6104 Aneurysms

Bones, Joints and Muscles

4239 Gout

Cancer

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

Cardiovascular Health

6101 Abnormal Heartbeat
6113 Chest Pain (Other Than Angina)
6116 Cholesterol - "Good" and "Bad"
6119 Congestive Heart Failure
6129 Early Warning of Heart Attack
6144 High Blood Pressure and Heart Disease
6170 Triglycerides

Common Illnesses

4332 Eczema

Digestive System

5400 Anal Fissure and Fistulas
4411 Colitis
4412 Constipation in the Digestive System
5402 Crohn's Disease
4413 Diarrhea in the Digestive System

Digestive System (continued)

4422 Diverticulosis and Diverticulitis
5404 Gallbladder Disease
5406 Gastroenteritis
4415 Heartburn and the Digestive System
4416 Hemorrhoids
5411 Intestinal Gas
4419 Irritable Bowel Syndrome
5414 Pancreatitis
5416 Rectal Bleeding
4421 Ulcers – Overview

Ear, Nose and Throat

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

Eyes and Vision

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

Hormonal Disorders

4701 Hyperthyroidism (Overactive Thyroid)
4702 Hypothyroidism (Underactive Thyroid

Infectious Diseases

4735 Fifth Disease
4724 Lyme Disease

Men's Health

4764 Prostate Problems

Mental and Emotional Health

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

Respiratory Problems

4933 Chronic Cough - A Significant Respiratory Problem
4934 Emphysema

Sexually Transmitted Diseases

4951 Chlamydia
4953 Herpes
4955 Syphilis

Skin Health

4975 Psoriasis

Sports Medicine

7462 Tendonitis

Stress and How to Cope

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

Symptoms

6127 Dizziness as a Symptom

Teenage Concerns

5227 Homosexuality
5228 Masturbation

Tests and Examinations

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

Urinary and Genital Systems

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

Weight Control

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

Women's Health

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

Other Categories:

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