Empire's Direct POS℠ Plan for Hofstra University Local 550 & Local 282 Group 720508-S3

Direct POS℠

5/2013

Welcome!

Welcome to Empire's Direct POS (Point-of-Service). When you selected Empire, you made a smart choice. With your Direct POS, you have access to flexible, quality health care coverage. This benefit book explains how you get health care services, summarizes what your health plan covers and how we can help you make the most of your plan.

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

Important: This is <u>not</u> an insured benefit Plan. The benefits described in this benefit book or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Empire BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

What's the Empire Direct POS Advantage?

The main advantage of this plan is choice. Choice that allows you to make smart decisions about your health care. Other advantages include:

- the ability to choose in-network or out-of-network care for most covered services.
- the freedom to self-refer to the network specialist of your choice for covered services.
- a comprehensive website, *www.empireblue.com*, for fast, personalized service in a confidential environment.
- lower costs when you use providers who are in Empire's participating provider network ("In-Network Providers").
- easy to use — usually no claim forms to file when you stay in-network.
- coverage when outside your service area.
- access to a large network of doctors and hospitals.
- providers that are reviewed for Empire's high standards of quality.

Your Empire Direct POS– A Smart Way to Get Health Care

Your Direct POS plan consists of in-network coverage issued by Empire HealthChoice HMO, Inc., d/b/a Empire BlueCross BlueShield HMO, and out-of-network coverage issued by Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross BlueShield. In this benefit book, the term "Empire" will be used to describe Empire BlueCross BlueShield and Empire BlueCross BlueShield HMO. Under the Direct POS, the network of health care providers is made available to you through Empire BlueCross BlueShield and our affiliate in Connecticut, Anthem Blue Cross and Blue Shield (the "POS Network").

Our "POS Network" consists of health care providers who have agreed to provide services to Empire's members. Depending on the health care service you need, you have a choice. For most services, including office visits to your doctor and inpatient hospital care, you can choose providers who either participate in the POS Network, or you can choose outside providers at a higher cost to you.

You get the most advantages when you use POS Network Providers because your out-of-pocket costs are lower and your providers must call medical management for those services requiring precertification. Using the POS Network is a smart way to save money and get the care you need.

How to Use This Book

This benefit book gives you an overview of how to use your Direct POS plan. Use this book as a guide whenever you or a covered family member need health care services.

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

Member benefit books are also available on audiotape for visually impaired members. To request an audiotape, call Member Services at 1-800-435-1385.

Here's a quick reference to the information you'll need.

Information About Your Plan is Available Online

Information about your Empire health plan is also available to you online, by registering on our Member website at *www.empireblue.com*. Once you register, you will have access to your plan's covered services, exclusions and limitations, and your cost sharing responsibilities.

Our Role in Notifying You

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

Note: This booklet contains summary information about the Direct POS program. The Direct POS program is subject to the terms, conditions and limitations in your Contract or Certificate. If there is a difference between this information and the actual Contract or Certificate, the Contract or Certificate terms will apply. To receive maximum benefits, you must comply with the terms and conditions of the Direct POS program Contract or Certificate and any applicable riders.

Your Direct POS Guide

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Introduction

Getting Answers Your Way

Empire gives you many ways to contact us with customer service questions. Use the Internet, phone or mail to get the information you need, when you need it.

By Telephone

WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership To select or change your PCP To locate a participating behavioral healthcare provider in your area Precertification of mental health and alcohol/substance abuse care	**1-800-435-1385** TDD for hearing impaired: **1-800-241-6894** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-435-1385** 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® PROGRAM	When you need urgent or emergency care outside of the Local Network Area	**1-800-810-BLUE (2583)** *www.bcbs.com* 24 hours a day, 7 days a week
BLUECARD® WORLDWIDE PROGRAM	Get benefits while you are away from home through an international network of health care providers	**1-804-673-1177** **24 hours a day, 7 days a week.**
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures	**1-800-845-4742** 8:30 a.m. to 5:00 p.m. Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
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

On the Internet

Do you have customer service inquiries and need a quick response? Visit our website at *www.empireblue.com*.
At Empire we understand that getting answers quickly is important to you. Many benefits, claims or membership questions or transactions can be quickly addressed online, simply and confidentially.

In Writing

Empire BlueCross BlueShield
Direct POS Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

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

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

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

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

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

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

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

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

Get health information for you and your family.

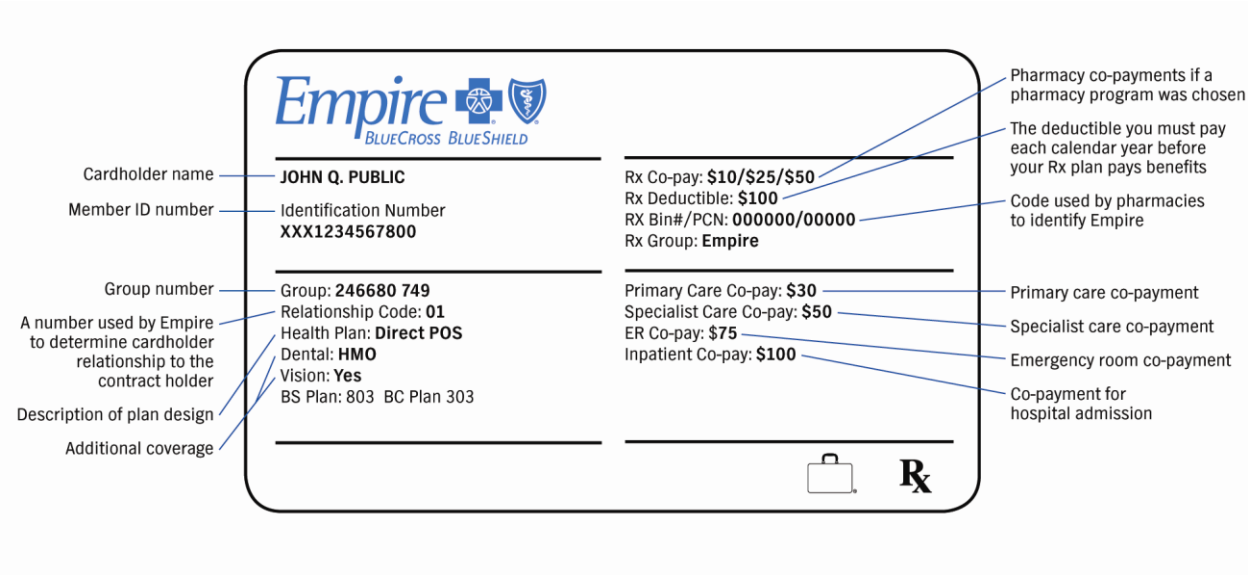
YOUR PRIVACY IS PROTECTED

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

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

Your Identification Card

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



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

Q. Why does each family member get a separate identification 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 to verify eligibility. (In a few instances, family members in some groups will receive two identification cards in the member's name only. These cards will be used for all family members.)

Q. I lost my identification card. How can I get a replacement?

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

Note:
The amount of your office visit co-payment depends on your group's coverage. You will either have one co-payment amount for all types of physician office visits or two co-payment amounts. If you have two co-payment amounts, one co-payment is for primary care (PRIM), such as visits to your primary care physician (PCP), obstetrician, or gynecologist and the second co-payment is for specialists (SPEC).

Using Your Direct POS

Know the Basics

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

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

USE YOUR PPO TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your Direct POS to your best advantage will help ensure that you receive access to quality health care — with maximum benefits. Here are four ways to get the most from your coverage.

1) 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.

2) WHEN YOU CHOOSE A PRIMARY CARE PHYSICIAN (PCP). The PCP you choose must be participating with the POS Network. But you do not need a referral to see specialists for covered services.

3) PLEASE REMEMBER TO PRECERTIFY hospital admissions and certain treatments and procedures. 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.

4) ASK QUESTIONS about your healthcare options and coverage. To find answers, you can

- Read the summary information in this book.
- call Member Services
- call *24/7 NurseLine and AudioHealth Library* — available to you 24 hours a day, seven days a week — to get recorded general health information, or to speak to a nurse to discuss health care options and more.

CHOOSING IN-NETWORK OR OUT-OF-NETWORK SERVICES

The key to using your Direct POS is to understand which benefits are available both in-network or out-of-network, which benefits are available only through In-Network Providers, and how benefits are paid. Your choice determines the level of benefits you will receive.

In-Network Services

Your Direct POS offers in-network coverage only for services rendered by In-Network Providers in the Local Network Area*, or by any providers for emergency care provided by an emergency room or hospital. . You have free choice to select any In-Network Provider for medically necessary covered services. You do not need a referral to see an In-Network Provider who is a specialist. You have other network advantages as well: low cost for covered services and usually no claim forms to file. Benefits are paid after a co-payment for office visits and certain covered services.

This is a Point of Service (POS) plan for all Members. Members receiving services outside of New York will use the BlueCard National PPO network to access their In-Network benefits, but members receiving services within the Local Network Area will continue to use the POS Network of Providers to receive In-Network benefits. If you are a Member outside of the Local Network Area in a state that participates in an Alternate Network arrangement, please call the Customer Service number on the back of your Identification Card to locate participating providers.

*The Local Network Area is the geographic area comprised of 28 counties in eastern New York State (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 and Westchester), and the following Connecticut counties, which are located in the service area of Empire's affiliate, Anthem Blue Cross and Blue Shield, Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.

Most covered services are available under your Direct POS, from either In-Network Providers or Out-of-Network Providers. However, some services are only covered in-network and only if your group purchased a rider to provide the benefit.

If your coverage includes these services and you use an Out-of-Network Provider, no benefits will be paid. Refer to your Directory of Providers to be sure you select network providers to get benefits for these services.

Out-of-Network Services

Out-of-network services are health care services provided by a licensed provider outside the POS Network. When you use out-of-network services,

- your out-of-pocket cost will be higher because you are subject to deductible and coinsurance, plus any amount above Empire's maximum allowed amount payment.
- you will usually have to pay the provider when you receive care.
- you will have to file a claim with us for reimbursement.

Coverage Outside the Local Network Area

BlueCard® PPO Program

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

BlueCard® Worldwide Program

The BlueCard Worldwide program provides emergency hospital and professional coverage through an international network of health care providers. With this program, you're assured of receiving emergency care from licensed health care 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.
- Show your Empire ID card at the hospital. If you're admitted, call the BlueCard Worldwide Service Center. The Service Center will ensure that you only pay for expenses not covered by your contract, such as co-payments and personal items. Remember to call Empire within 24 hours, or as soon as reasonably possible.
- If you receive emergency 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 health care provider or by calling the BlueCard Worldwide Program. Mail the claim to the address on the form. Call Member Services at 1-800-435-1385 for more information.

If you need non-emergency medical care, you must call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization at a BlueCard Worldwide hospital or provide you with an outpatient referral. It is important that you call the BlueCard Worldwide Service Center to ensure that you only pay the usual out-of-pocket expenses. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

How Benefits Are Paid

In-network benefits are paid after a co-payment for office visits, certain outpatient covered services and any other services. Refer to Your Benefits At A Glance section for more details.

Your Direct POS has one of the following types of co-payments. You can tell which applies to you by looking at Your Benefits At A Glance section.

- One co-payment amount (OFC), which is the same for PCP and all specialist office visits.
- Two co-payment amounts (PRIM and SPEC): one co-payment (PRIM) for primary care visits (such as your primary care physician (PCP), obstetrician, gynecologist) and a different co-payment (SPEC) for all other specialists. (The following chart lists which providers receive PRIM co-payment and which ones receive SPEC co-payment.)

PRIMARY (PRIM) CO-PAYMENT	SPECIALIST (SPEC) CO-PAYMENT
Your PCP	**All other specialists (with the exception of those listed in the column to the left)**
Your PCP back-up	
Obstetricians/Gynecologists	
Specialty Care Coordinators	
Certified Nurse Midwives	
Nurse Practitioner	
Preventive Medicine	
Geriatrics	
Internal Medicine	
Pediatrics	
General Practitioner	
Family Practitioner	
Therapists — Physical, Speech, Language, Occupational and Vision (These visits must take place in the provider's office.)	

This chart only applies to members that have "PRIM" and "SPEC" co-payments

Out-of-network benefits are paid after you meet your individual or family deductible. Once your deductible is met, you and the plan share the cost. You and the plan each pay a percentage, called coinsurance, of Empire's maximum allowed amount for a covered service. You are responsible for the cost of any services that are not covered or for any amount in excess of the maximum allowed amount. You pay your deductible and coinsurance up to an annual out-of-pocket maximum, plus any difference between the providers charge and the Empire maximum allowed amount.* That difference does not apply toward the out-of-pocket maximum.

*Reminder: Providers with other Blue Cross and/or Blue Shield Plans who participate in the traditional (non-PPO) BlueCard program are out-of-network for non-emergency care, but may not "balance bill" you beyond the maximum allowed amount. Therefore, your out-of-pocket costs will be less than for other providers who may bill you up to full charges. See the "Your Empire Direct POS Out-of-Area Benefits and the BlueCard® Program**"** section**.**

How Deductible and Coinsurance Are Applied for Out-of-Network Services

If you have individual coverage:

- Deductible and coinsurance amounts will be applied for covered out-of-network services, until the annual individual deductible and coinsurance are met.

If you have family coverage:

- The individual deductible and coinsurance amounts apply to each family member, for covered out-of-network services, until the annual family deductible and coinsurance maximums are met. Once the first family member meets the annual individual deductible, that family member will pay coinsurance up to the annual individual coinsurance maximum. The next family member must also meet the annual individual deductible and coinsurance amounts. This will apply until the annual family deductible and coinsurance maximums are met. Once the annual family deductible and coinsurance maximums are met, your Direct POS will pay benefits for 100% of covered out-of-network services during the remainder of the year, for all eligible family members (except for out-of-network services from non-participating providers, for which you still pay the difference between the maximum allowed amount and charges).

How Providers are Reimbursed

We pay participating providers, as follows:

- **Participating professional providers (e.g., physicians and other licensed health care professionals)**: based on our fee schedule developed for each procedure or service.

- **Participating hospitals:** based on the rate we have negotiated for inpatient and outpatient services.

- **Participating institutional/facility based providers (e.g., ambulance, home health agencies, free standing ambulatory surgery centers, hospices)**: based on a negotiated rate or our fee schedule developed for each procedure or service.

In some cases, we reimburse providers on a capitation basis. Capitation means that we pay providers a fixed dollar amount in advance on a per member per month basis. Under a capitation payment method, providers receive this fixed amount regardless of the number of services they provide to a member. We use capitation for certain doctor groups and physician organizations, such as independent practice association s (IPAs).

We pay non-participating providers based on a maximum allowed amount. When you visit a non-participating provider, you are responsible for the difference between our payment and the provider's charge. For example, if your contract requires 20% coinsurance and the provider's charge is $100, and our maximum allowed amount for the service at issue is $60.00, you must pay coinsurance of $12.00, plus the $40.00 difference between our payment and the provider's charge, for a total of $52.00

If You Have Questions About a Benefit Payment

Empire reviews each claim for payment purposes to confirm that it is for medically necessary covered services and contains 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 financial responsibility on the claim other than your co-payment amount.

The EOB may also include

- the specific reason(s) for any denial or reduction in benefits.
- references to the pertinent plan provisions on which the denial or reduction 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 grievance and appeals 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 1-800-435-1385 or in writing for more information. When you call, be sure to have your Empire ID card number handy, along with any information about your claim.

Send written inquiries to**:**

Empire BlueCross BlueShield
Direct POS Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

In-Network Services: Working With Your Primary Care Physician (PCP)

The Empire Direct POS makes it easy to get most of the health care that you need through your PCP. Whenever you need routine or preventive medical care you should see your PCP. Your PCP will

- provide basic and preventive care such as routine checkups and screening tests.
- help you select a network specialist, if needed (you do not need a referral to see specialists for covered services).
- maintain your medical history.
- help you arrange hospital admissions and other special services.
- coordinate precertification of services with Empire's Medical Management Program when required, for example, inpatient care.

You and each covered family member select a PCP when you enroll. Family members can use the same PCP or select their own. A PCP can be an internist, general or family practitioner, or a pediatrician (for children) who is an active In-Network Provider. If you do not select a PCP upon enrollment, Empire will assign one to you.

Tips for Selecting a PCP

Take time to choose your PCP. As a member of Empire's Direct POS, you may choose from some of the finest physicians in the Local Network Area (see the Definitions section for a definition of Local Network Area).

HOW TO ACCESS PRIMARY AND SPECIALTY CARE SERVICES

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

To make an appointment call your physician's office:

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

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

When you need care after normal office hours

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

How to locate In-Network Providers

To locate an In-Network Provider, visit *www.empireblue*.com and click on "Find a Doctor," then on "In Empire's *local area medical network*". 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.

If the listing for a PCP says "practice available to current patients only," you need to select a different PCP, unless you are already a patient.

Now you can customize your provider directory. Provide us with only your ID and zip code and we will provide a compact, printable directory just for you. You can also call Member Services at 1-800-435-1385 to request that a printed Provider Directory be mailed to you free of charge.

Look for a PCP who

- is located near your home or office.
- speaks your preferred language if your primary language is not English.
- is affiliated with a network hospital that
  • is located conveniently for you, and
  • offers services that suit your needs.

Call the office of the PCP you are considering. Ask a few questions about the doctor's services to help you decide if the PCP is a good choice for you. For example, what are the office hours? Do they include evenings and Saturdays? How long is the usual waiting time to see the doctor? How large is the practice?

Tips for PCP Visits

- If you are a new patient, confirm that the doctor remains in the network when you call for an appointment.
- You will need your ID card and should be prepared to spend a little extra time to complete the initial patient forms on your first visit.

Changing Your PCP

You can change your PCP at any time by visiting *www.empireblue.com* or calling Member Services at 1-800-435-1385. Changes are generally effective immediately.

If your plan has one co-payment for primary care visits (such as your primary care physician (PCP), obstetrician, gynecologist) and a different co-payment for specialists, and you change your PCP, please confirm that Empire has made the change before your office visit with this new doctor, or you may be required to pay the higher specialist co-payment.

Need to See a Specialist?

Your Direct POS allows you to self-refer to any network specialist of your choice for medically necessary covered services. To locate a network specialist, check your Provider Directory or visit *www.empireblue.com*, go to "*Find a Doctor*", then "*Empire's local area medical network*". You may also call Member Services for help in locating a specialist or to confirm that the specialist you have chosen is an active In-Network Provider. And don't forget about asking your PCP for help. He or she has a wealth of information about resources available in your community and can direct you to an appropriate specialist for your condition. You are not required to ask your PCP for help or permission — the choice is yours and you may change your specialist at anytime.

Tips for Visiting a Specialist

- Be sure to visit a network specialist to receive in-network benefits.
- Although you may self-refer to any network specialist for covered services, you may ask your PCP for help in selecting an appropriate specialist.
- Arrange to have copies of pertinent medical records and test results sent to the specialist in advance or bring them with you.
- Think about what you want to say before you see the specialist. Write down the history of your condition in date order to help the doctor evaluate your present condition.
- Talk to the specialist about treatment options. Go over the benefits and risks associated with each option.

Provider Quality

Whichever network PCP or specialist you choose from the POS Network, you can be assured that they meet quality standards established by Empire, or its affiliate, Anthem Blue Cross and Blue Shield. The background and credentials of the In-Network Providers listed in our directory are carefully reviewed before acceptance into the POS Network. Once these providers have been accepted into the network, ongoing quality checks are made and they are formally reviewed every three years to make sure they maintain the required standards.

Among other requirements, In-Network Providers who are doctors must:

- be a graduate of an accredited college of medicine or osteopathy.
- hold valid state licenses.
- have admitting privileges at a network hospital (or an acceptable alternative to admitting privileges).
- have the required level of malpractice insurance.

In-Network Providers are expected to:

- make appointments in a reasonable period of time for
  – routine physical exams — within four weeks.
  – treatment of symptoms of illness or injury — within 72 hours.
  – treatment of urgent situations — within 24 hours.
  – treatment for emergency situations — within two hours.
  – for initial newborn care — within two weeks.
  – for routine follow-up care — within two weeks.
- agree to see patients promptly when they have an appointment.
- have 24-hour network physician backup (for PCPs).
- meet appropriate professional and ethical standards.

Learn More About Empire Network Doctors

You can get information on the professional qualifications of our network providers by calling Member Services at 1-800-435-1385, or by visiting *www.empireblue.com* or the American Medical Association's website, *www.ama-assn.org/aps/amalg.htm*.

Transitional Care

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

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

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

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

The Advantages of Specialty Care Coordinators and Specialty Care Centers

If you have a life-threatening or degenerative and disabling condition or disease, you may request a Specialty Care Coordinator (SCC) to act as your PCP. An SCC is a network specialist with expertise in treating the disabling and degenerative or life-threatening condition. The Specialty Care Coordinator can refer you to a Specialty Care Center, and will coordinate your care while you are receiving specialized services. If your plan has PRIM and SPEC co-payments, you pay your SCC the PRIM co-payment.

If you would like to request that an SCC function as your PCP, your PCP must call Empire's Medical Management Program. Empire and your doctor, together with Empire's medical director and your specialist, must approve all SCC requests. Your care by the SCC will be given according to a treatment plan reviewed by Empire in consultation with you, your PCP and the SCC. Even without designating a network specialist to serve as your PCP, you may self-refer to that specialist for medically necessary covered services whenever you need care. The advantage of naming an SCC as your PCP is that you can rely on the physician most responsible for your care, should a serious situation arise.

Examples of Specialty Care Centers include centers for the treatment of:

- HIV/AIDS (designated by the New York State AIDS Institute)

- Cerebral palsy (accredited by the New York State Department of Health)
- Cystic fibrosis (designated by the Cystic Fibrosis Foundation)
- Cancer (accredited by the National® Cancer Institute)[3]
- Organ transplants (accredited by Medicare)
- Hemophilia (designated by the National Hemophilia Foundation)
- Multiple sclerosis (designated by the National Multiple Sclerosis Society)
- Sickle cell disease (accredited by the National Institutes of Health)

When visiting a new doctor, especially a specialist, think about the following questions. What should you ask? How do you prepare? What should you bring? Since your time is important, Empire can help you with these questions. See the "My Health" and "You and Your Doctor" sections at *www.empireblue.com*. We will show you step by step how to prepare for your specialist visit.

Out-of-Network Referrals

HMO members may request a referral to an Out-of-Network Provider in the event they believe that Empire's network does not have a provider with appropriate training and experience to adequately treat the member's condition. Requests should be submitted to Medical Management through one of the following means: by phone at 1-800-982-8089; by fax at 1-518-367-5362; or by mail to the address below. We may ask for documentation describing in detail the member's condition and proposed treatment. To the extent the member has consulted with participating providers, we may also request documentation of any opinions provided by such providers. Finally, we may request a detailed description of any proposed course of treatment suggested by the Out-of-Network Provider to whom the referral is sought. We will render a decision on the request for an out-of-network referral within 72 hours of our receipt of all necessary information. If the referral is denied on the basis that such out-of-network health service is not materially different than the health services available in-network, the member may appeal the decision through Empire's grievance/appeal procedures. Additional information (e.g. physician certification, medical and scientific documentation, etc.) will be required. If the referral is approved, the member will incur no financial liability beyond the required in-network co-payments established for the service provided.

Address: Empire BC/BS
Mail Drop 2A
11 Corporate Woods Blvd.
Albany, NY 12211

Your Benefits At A Glance

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

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

	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE*	$0	$250/Individual $500/Family
CO-PAYMENT (for office visits and certain covered services)	$15 Primary co-payment per visit $25 Specialist co-payment per visit	N/A
CO-PAYMENT (for hospital inpatient admissions)	$0	N/A
CO-PAYMENT (for emergency room)	$25 per visit (waived if admitted to hospital within 24 hours)	$25 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	N/A	You pay 30% of maximum allowed amount Plan pays 70% of maximum allowed amount
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	N/A	$3,000/Individual $6,000/Family
LIFETIME MAXIMUM	Unlimited	Unlimited

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

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
HOME/OFFICE VISITS	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance
SPECIALIST VISITS	$25 co-payment per visit	Deductible and 30% coinsurance
CHIROPRACTIC CARE • Up to 20 visits (combined in-network and out-of-network)	$25 Specialist co-payment per visit	Deductible and 30% coinsurance
SECOND OR THIRD SURGICAL OPINION	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy • Laboratory tests • MRIs/MRAs • Nuclear cardiology services • PET/CAT scans	$25 co-payment per visit (No co-payment will apply for interpretation only, or if a co-payment applied for office visit; only one co-payment per provider)	Deductible and 30% coinsurance
DIABETES EDUCATION AND MANAGEMENT	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance
ALLERGY CARE • Office Visit • Testing • Treatment	$15 Primary co-payment per visit $25 Specialist co-payment per visit $0 $0	Deductible and 30% coinsurance
SURGERY	$0	Deductible and 30% coinsurance
PRE-SURGICAL TESTING	$0	Deductible and 30% coinsurance
ANESTHESIA	$0	Deductible and 30% coinsurance
CHEMOTHERAPY, RADIATION	$0	Deductible and 30% coinsurance
KIDNEY DIALYSIS	$0	Deductible and 30% coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance
CARDIAC REHABILITATION • Up to 30 visits per calendar year	$0	Deductible and 30% coinsurance

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

	YOU PAY	
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL PHYSICAL EXAM • One per calendar year	$0	Not covered
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Over age 50-: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age • Diagnostic PSA: 1 per year	$0 $0 $0 $0 $0	Deductible and 30% coinsurance
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment – Ages 52 through 65 - 1 baseline – Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)* • Mammogram (based on age and medical history) – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year • Women's sterilization procedures and counseling • Breastfeeding support, supplies and counseling – One breast pump per year • Screenings and/or counseling for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections STIs), Human immune deficiency (HIV), interpersonal and domestic violence.	$0 $0 $0 $0 $0 $0	Deductible and 30% coinsurance
WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits – Newborn: 2 in-hospital exams at birth following vaginal delivery – Newborn: 4 in-hospital exams at birth following c-section delivery • Office visits – From birth up 1st birthday: 7 visits – Ages 1 through 4 years of age: 7 visits – Ages 5 through 11 years of age: 7 visits – Ages 12 through 17 years of age: 6 visits – Ages 18 to 21st birthday: 2 visits • Lab tests ordered at the well-child visits and performed in the office or in the laboratory • Certain immunizations (office visits are not required)	$0 $0 $0 $0	Deductible and 30% coinsurance

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

	YOU PAY	
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
EMERGENCY ROOM	$25 co-payment per visit (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	$0	Covered in-network when specified criteria is met; subject to any applicable cost sharing. You may be required to pay the difference between the maximum allowed amount and the total charges of an out-of-network provider.
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0	Covered in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the maximum allowed amount and the provider's total charges.*
MATERNITY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
PRENATAL AND POSTNATAL CARE (In doctor's office)	**No Copayment** applies to Physician office visits for routine prenatal care after the first visit in which a $15 copayment applies. For non-routine care, even after the first visit, a $15 copayment applies.	Deductible and 30% coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	$0	Deductible and 30% coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	$0	Deductible and 30% coinsurance
OBSTETRICAL CARE (In hospital)	$0	Deductible and 30% coinsurance
OBSTETRICAL CARE (In birthing center)	$0	Not covered

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

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

	YOU PAY	
HOSPITAL SERVICES*[1]	**IN-NETWORK**	**OUT-OF-NETWORK**
SEMI-PRIVATE ROOM AND BOARD	$0	Deductible and 30% coinsurance
ANESTHESIA AND OXYGEN	$0	Deductible and 30% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	$0	Deductible and 30% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	$0	Deductible and 30% coinsurance
DRUGS AND DRESSINGS	$0	Deductible and 30% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	$0	Deductible and 30% coinsurance
INTENSIVE CARE	$0	Deductible and 30% coinsurance
KIDNEY DIALYSIS	$0	Deductible and 30% coinsurance
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	$0	Deductible and 30% coinsurance
SURGERY (Inpatient and Outpatient) **	$0	Deductible and 30% coinsurance
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK**
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	$0	Deductible and 30% coinsurance
ORTHOTICS (Coverage only includes orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician.)	$0	Deductible and 30% coinsurance
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	$0	Deductible and 30% coinsurance
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	$0	Difference between the maximum allowed amount and the total charge (deductible and coinsurance do not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	$0	Deductible and 30% coinsurance

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

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

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

[1] *Residential treatment services are not covered*

	YOU PAY	
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY Up to 60 days per calendar year	$0	Not covered
HOSPICE Up to 210 days per lifetime	$0	Deductible and 30% coinsurance
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
HOME HEALTH CARE • Up to 40 days per calendar year combined in-network and out-of-network (a visit equals 4 hours of care) **	$0	30% coinsurance only No deductible
HOME INFUSION THERAPY	$0	Deductible and 30% coinsurance
PRIVATE DUTY NURSING (unlimited in the home)	$0	Deductible and 30% coinsurance
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICAL THERAPY AND REHABILITATION • Up to 30 days of inpatient service per calendar year **	$0	Deductible and 30% coinsurance
• Up to 30 visits combined in home, office or outpatient facility per calendar year	$0	Deductible and 30% coinsurance
OCCUPATIONAL, SPEECH, VISION THERAPY • Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$0	Deductible and 30% coinsurance

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

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

	YOU PAY	
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits	**Outpatient Facility** $0 **Outpatient Office** $15 co-payment per visit	Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days • Unlimited number of medically necessary visits from mental healthcare professionals	$0 $0	Deductible and 30% coinsurance Deductible and 30% coinsurance
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-OF-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits, including visits for family counseling	**Outpatient Facility** $0 **Outpatient Office** $15 co-payment per visit	Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days of detoxification • Unlimited number of medically necessary rehabilitation days	$0 $0	Deductible and 30% coinsurance Deductible and 30% coinsurance
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
TRAVEL AND LODGING FOR ORGAN TRANSPLANTS • $10,000 lifetime maximum (when facility is greater than 50 miles from member)	$0	Deductible and 30% coinsurance
ACUPUNCTURE	$15 Primary co-payment per visit $25 Specialist co-payment per visit	Deductible and 30% coinsurance

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

Coverage

Doctor's Services

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

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

Tips For Visiting Your Doctor

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

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

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 self-management education and diet information, including:
  - Education by a physician, certified nurse practitioner or member of their staff:
    - At the time of diagnosis
    - When the patient's condition changes significantly
    - When medically necessary
  - Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian when referred by a physician or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.
  - Home visits for education when medically necessary
- Diagnosis and treatment of degenerative joint disease related to temporomandibular joint (TMJ) syndrome that is not a dental condition
- Diagnosis and treatment for Orthognathic surgery that is not a dental condition
- Medically necessary hearing examinations
- Foot care and orthotics associated with disease affecting the lower limbs, such as severe diabetes, which requires care from a podiatrist or physician
- Chiropractic care

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

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 vision 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

Preventive Services

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

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

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

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

Examples of these services are screenings for:

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

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations, including the well-child care immunizations as listed below:

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

C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") including:

- Well-child care visits to a pediatrician, nurse or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, and guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory. Covered services and the number of visits covered per year are based on the prevailing clinical standards of the American Academy of Pediatrics (AAP) and will be determined by your child's age.

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

  For individuals who are:
  – Ages 52 through 65 - 1 baseline

- Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)
- Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

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

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

- Well-woman care visits to a gynecologist/obstetrician

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

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

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

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

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

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

Emergency and Urgent Care

IF YOU NEED EMERGENCY CARE

Should you need emergency care, Empire's Direct POS is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

4. Serious disfigurement of such person.

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

Emergency Services are not subject to prior authorization requirements.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room or urgent care center. If possible, go to the emergency room of a hospital where your PCP is affiliated or one that is in the POS Network. You may contact member services for a list of participating hospitals, or visit us at *www.empireblue.com*.

You pay a co-payment for a visit to an emergency room. The emergency room co-payment is waived if you are admitted to the hospital within 24 hours. You will need to show your identification card when you arrive at the emergency room. If you make an emergency visit to your PCP's office, you pay the same co-payment as for an office visit. See Your Benefits At A Glance section for co-payment amounts.

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 the Local Network Area but in the United States, follow the same steps described above. If the hospital participates with another Blue Cross and/or Blue Shield plan, you claim will be processed by the local Blue Cross and/or Blue Shield plan. Be sure to show your Empire I.D. card at the emergency room. If the hospital does not participate with a Blue Cross and/or Blue Shield program, you will need to file a claim, but emergency services will be covered on an in-network basis.
- If you have an emergency outside of the United States and visit a hospital which participates in the BlueCard® Worldwide program, simply show your Empire I.D. card. The hospital will submit their bill through the BlueCard Worldwide Program. If the hospital does not participate with the BlueCard Worldwide program, you will need to file a claim.

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

What's Not Covered

These emergency services are not covered:

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

Emergency Air Ambulance

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

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

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

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

Emergency Land Ambulance

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

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

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

If You Need Urgent Care

Urgent care is care required in order to prevent serious deterioration to your health. It is the type of care that requires timely attention (i.e., bronchitis, high fever, sprained ankle), but is not an emergency. Urgent care is covered in an urgent care center or in your physician's office.

If you are in the Local Network Area and need urgent or after-hours care, call your PCP or your PCP's backup. Your PCP is required to have coverage 24 hours a day, seven days a week so you have access to urgent care. You can also call 24/7 NurseLine for advice from a registered nurse at 1-877-TALK-2RN (1-877-825-5276) 24 hours a day, seven days a week.

For urgent care in the Local Network Area, you may receive in-network or out-of-network benefits. If you visit an in-network doctor or urgent care center, you pay a co-payment. If you visit an out-of-network doctor or urgent care center, you pay a deductible and coinsurance.

For urgent care outside of the Local Network Area, you pay a deductible and coinsurance.

Maternity Care

IF YOU ARE HAVING A BABY

There are no out-of-pocket expenses for routine maternity and newborn care when you use in-network providers after your first visit for prenatal care. That means for routine care, you do not need to pay a co-payment when you visit the obstetrician after your first visit for prenatal care (For non-routine care, copayments apply). 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.

Routine pregnancy costs includes payments to the obstetrician for all office visits related to the healthy pregnancy, blood tests and ultrasound, as recommended by the American College of OB/GYN, labor and delivery with regional anesthesia. Office visits for a problem, whether or not the problem is related to the pregnancy, are not considered routine pregnancy costs.

Non-routine care includes other laboratory tests, genetic testing, amniocentesis, problem directed ultrasounds, and evaluation for or treatment of any diseases.

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

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

What's Covered

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

- One home care visit if the mother leaves earlier than the 48-hour (or 96-hour) limit. The mother must request the visit from the hospital or a home health care agency within this timeframe. 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 performed in the hospital
- Special care for the baby if the baby stays in the hospital longer than the mother.
- Semi-private room

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

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.**

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).

FUTURE MOMS PROGRAM

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

While most pregnancies end successfully with a healthy mother and baby, Empire's Future Moms 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 healthcare referrals and health education counseling.

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

Hospital Services

IF YOU VISIT THE HOSPITAL

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

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

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

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

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

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

Pre-Surgical Testing

Benefits are available for pre-surgical testing on an outpatient basis, when performed at the Hospital where the surgery is scheduled to take place, if:

- reservations for a Hospital bed and for an operating room at that Hospital have been made prior to performance of the tests;
- the Covered Person's doctor has ordered the tests; and
- proper diagnosis and treatment require the tests.

The surgery must take place within seven (7) days after these tests. If surgery is canceled because of these pre-surgical test findings or as a result of a voluntary second opinion on surgery, we will still cover the cost of these tests, but they will not be covered when the surgery is canceled for any other reason.

Tip For Getting Hospital Care

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

Inpatient And Outpatient Hospital Care

What's Covered

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

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

Inpatient Hospital Care

What's Covered

Following are additional covered services for inpatient care:

- Semi-private room and board when
  - The patient is under the care of a physician, and
  - A hospital stay is medically necessary.
- Coverage is for unlimited days, unless otherwise specified
- Operating and recovery rooms
- Special diet and nutritional services while in the hospital
- Cardiac care unit
- Services of a licensed physician or surgeon employed by the hospital
- Care related to surgery
- Breast cancer surgery (lumpectomy, mastectomy), including:
  - Reconstruction following surgery
  - Surgery on the other breast to produce a symmetrical appearance
  - Prostheses
  - Treatment of physical complications at any stage of a mastectomy, including lymphedemas

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

Outpatient Hospital Care

What's Covered

Following are additional covered services for same-day care:

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

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

Inpatient Hospital Care

What's Not Covered

These inpatient services are not covered:

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

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 PROSTHETICS, ORTHOTICS, MEDICAL EQUIPMENT OR SUPPLIES

Your plan covers the cost of medically necessary durable medical equipment, prosthetics and orthotics from in-network and out-of-network suppliers. In-network and out-of-network benefits and plan maximums are shown in *Your Benefits At A Glance section*.

- An Empire network supplier may not bill you for covered services. If you receive a bill from one of these providers, contact Empire Member Services at 1-800-435-1385.
- You must submit a claim form if you receive prosthetics, orthotics or medical equipment from out-of-network suppliers.

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

Coverage for enteral formulas or other dietary supplements for certain severe conditions is available both in- and out-of network. If you have prescription drug coverage with Empire's pharmacy program, you may order these formulas or supplements through Empire's pharmacy program.

What's Covered

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

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

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

What's Not Covered

The following equipment is not covered

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

Skilled Nursing and Hospice Care

IF YOU NEED SKILLED NURSING OR HOSPICE CARE

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

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

Skilled Nursing Care

What's Covered

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

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

What's Not Covered

The following skilled nursing care services are not covered:

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

Hospice Care

Empire covers 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 hospital, or at home.

What's Covered

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

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

Tips for Receiving Skilled Nursing and Hospice Care

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

Home Health Care

IF YOU NEED HOME HEALTH CARE

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

Home infusion therapy, a service sometimes provided during home health care visits, is covered in-network and out-of-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 1-800-435-1385.

What's Covered

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

- Up to 40 home health care visits per year, combined in- and out-of-network. A visit is defined as up to four hours of care. Care can be given for up to 12 hours a day (three visits). Your physician must certify home health care as medically necessary and approve a written treatment plan.
- Home health care services include:
  - Part-time services by a registered nurse (RN) or licensed practical nurse (LPN)
  - Part-time home health aide services (skilled nursing care)
  - Physical, speech or occupational therapy, if restorative
  - Medications, medical equipment and supplies prescribed by a doctor
  - Laboratory tests
- Out-of-network home infusion therapy
- Unlimited private duty nursing in the home

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

Physical, Occupational, Speech or Vision Therapy

IF YOU NEED THERAPY

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

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

Tip for Receiving Therapy

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

What's Covered

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

- Physical therapy, physical medicine or rehabilitation services, or any combination of these on an 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.

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

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

What's Not Covered

The following therapy services are not covered:

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

Behavioral Healthcare

IF YOU NEED BEHAVIORAL HEALTHCARE

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

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

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

Mental Health Care

What's Covered

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

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

What's Not Covered

The following mental health care services are not covered:

- Care that is not medically necessary

Treatment for Alcohol or Substance Abuse

What's Covered

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

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

What's Not Covered

The following alcohol and substance abuse treatment services are not covered

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

Exclusions and Limitations

EXCLUSIONS

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

Dental Services

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

However, your plan does cover:

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

Experimental/Investigational Treatments

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

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

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

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 prescription drugs and over the counter drugs, self-administered injectables, vitamins, appetite suppressants, oral contraceptives, injectable contraceptives, contraceptive patches and diaphragms or any other type of medication, unless specifically indicated

Sterilization/Reproductive Technologies

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

Travel

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

Vision Care

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

War

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

Workers' Compensation

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

LIMITATION AS INDEPENDENT CONTRACTOR

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

Health Management

Empire's Medical Management Program

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

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

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

HOW EMPIRE'S MEDICAL MANAGEMENT PROGRAM HELPS YOU

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

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

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

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

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

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

IF SERVICES ARE NOT PRECERTIFIED

If you call to precertify services as needed, you will receive maximum benefits. If the admission or procedure is not medically necessary, no benefits will be paid.

Initial Decisions

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

- ***Precertification Requests.*** Precertification means that Empire's Medical Management Program must be contacted for approval before you receive certain health care services that are subject to precertification. We will review all non-urgent requests for precertification within three (3) business days of receipt of all necessary information but not to exceed 15 calendar days from the receipt of the request. If we do not have enough information to make a decision within 15 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal to denial of coverage decision.
- ***Urgent Precertification Requests.*** If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision, we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- ***Concurrent Requests.*** Concurrent review means that Empire reviews your ongoing care during your treatment or hospital stay to be sure you get the right care in the right setting and for the right length of time. When the request to continue care is received at least 24 hours before the last approved day, we will complete all concurrent reviews of services within 24 hours of our receipt of the request.
- ***Retrospective Requests.*** Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal the denial of coverage decision. If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

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

If a Request Is Denied

All denials of benefits for lack of medical necessity 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 the section in this handbook 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 Empire's Medical Management Program to reconsider their decision. A response will be provided by phone and in writing within one business day of making a decision.

New Medical Technology

REQUESTING COVERAGE

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

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

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

Case Management

IF YOU NEED ADDITIONAL SUPPORT FOR SERIOUS ILLNESS

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

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

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

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

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

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 & services, and alternative therapies
- Guidance and support for when you need help

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

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

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

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

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

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

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

Here's how to use 24/7 NurseLine:

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

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

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

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

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

Member Newsletter – Our semi-annual member newsletter, *Healthy Solutions*, 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 Guidelines – 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.

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 1-800-435-1385.

Eligibility

WHEN ARE YOU ELIGIBLE?

Your coverage under Empire's Direct POS 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.

COVERAGE CATEGORY

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

- Individual, which covers only you
- Family, which covers you and one or more of the following:

ELIGIBLE DEPENDENTS

The following family members are eligible for coverage:

- Your spouse - an opposite sex or same-sex spouse to a marriage that is legally recognized in the jurisdiction (State or Country) in which it is performed. Former spouses, as a result of a divorce or annulment of a marriage, are not considered eligible spouses.
- Your children, including natural children, legally adopted children, stepchildren, and child of your domestic partner, until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered. Your children are no longer eligible when they are eligible for employer-sponsored coverage on their own.
- Your unmarried children, regardless of age, who are incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap, and who became so incapable prior to attainment of the age at which the dependent coverage would otherwise terminate.
- Your same-sex domestic partner. Please check with your Benefits Administrator for more information.

Your plan does not cover foster children.

Adding or Removing a Dependent

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are having a baby, getting married, getting divorced, or having your children no longer meet the eligibility requirements. The following circumstances may result in changes to your coverage:

- If you failed to enroll when you became eligible, you may enroll yourself or yourself and your dependents without waiting for the open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within thirty (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 eligible for coverage under this program if the following enrollment conditions are met:
  - You or eligible dependent was covered under another plan at the time coverage was initially offered, and
  - Coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
  - Contract holder contributions toward the payment of premium for the other plan were terminated, or
  - Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one of the following:
    - Termination of employment
    - Termination of the other plan
    - Death of the spouse
    - An employer no longer offers benefits to a class of individuals (i.e., part time workers)
    - Legal separation, divorce or annulment
    - Reduction in the number of hours of employment
    - Premium payments for the other plan were terminated
    - Lifetime maximum being met under such insurance

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

  Coverage must be applied for within thirty (30) days of one of the qualifying special enrollment events described above.
- If you marry and transfer to family coverage within 30 days of the marriage date, Empire will provide retroactive coverage during this period. Otherwise, coverage begins on the date Empire receives and accepts your completed enrollment form from your employer during the open enrollment period.
- Eligible Employees and Dependents may also enroll under two additional circumstances:
  - the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
  - the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

  The Employee or Dependent must request Special Enrollment within thirty (30) days of the loss of Medicaid/CHIP or of the eligibility determination.
- Enrolling a newborn child:
  - For a Member who has <u>individual (for self only), employee\spouse, or parent\child (two-person)</u> coverage:
    - He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within thirty (30) days after the date of birth.
    - He\she MUST formally add his\her **<u>eligible</u>** newborn or a proposed adopted newborn to his\her contract within thirty (30) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
    - If the Company does not receive enrollment notification within thirty (30) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form**.**
    - If you do not switch to a parent\child, parent\children, or family contract and enroll your **eligible** newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Plan, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery**.**
  - For a Member who has <u>family or parent\children</u> (more than two person) coverage:
    - An **eligible** newborn child, or a proposed adopted newborn, will be covered from the date of birth**.**
    - He\she MUST formally add his\her **eligible** newborn or a proposed adopted newborn to his\her contract within thirty (30) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.

- Coverage will still be effective from the date of birth for an **eligible** newborn or a proposed adopted newborn if an enrollment form is received after thirty (30) days, and enrollment will still be retroactive to the date of birth.
- Any claims for an **eligible** newborn or a proposed adopted newborn received after thirty (30) days will not be processed until the newborn or proposed adopted newborn is formally enrolled, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery**.**
- An adopted newborn is covered from the moment of birth if:
  - You take custody as soon as the infant is released from the hospital after birth,
  - The newborn is dependent upon you pending finalization of the adoption, and
  - You file an adoption petition within 31 days of the infant's birth.
- Adopted newborns will not be covered from the moment of birth if:
  - The infant has coverage from one of the natural parents for the newborn's initial hospital stay
  - A notice revoking the adoption has been filed
  - One of the natural parents revokes their consent to the adoption

- Qualified Medical Child Support Orders (QMCSO). A court order, judgment or decree that:
  - Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or
  - Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

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

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

Ending and Continuing Coverage

WHEN COVERAGE ENDS

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

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

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

Notice of Qualifying Events:

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

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

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

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

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

FOR MORE INFORMATION

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

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Plan Sponsor or the Group Benefits Administrator responsible for COBRA administration for your group.

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

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.

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.

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

If you are not entitled to continuation of coverage under COBRA (for example, your employer has less than 20 employees), you may be entitled to continue coverage under New York State Law. 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.

CONVERTING YOUR COVERAGE

Under certain circumstances, you may convert your group coverage to individual coverage with comparable benefits if such coverage is available from your group or, you may convert your group coverage to a Medicare supplement policy, if appropriate. However, not all your current benefits may be available when you convert your coverage. Please see your Benefits Administrator for details.

ENDING AND CONTINUING COVERAGE

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

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

IF YOU BECOME DISABLED

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

Coverage will end when the disabled person:

- Is no longer totally disabled
- Has received maximum benefits from the contract

- Becomes eligible for total disability under another group program

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

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

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

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

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

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

CARVE-OUT PROGRAM

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

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

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

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

PORTABILITY OF COVERAGE

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

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.

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

As a member of our plan, you can request a Certificate of Creditable Coverage letter at any time by calling Member Services at 1-800-435-1385.

CERTIFICATES OF CREDITABLE COVERAGE AFTER TERMINATION

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

Claims

If You Need to File a Claim

Your Empire Direct POS makes health care easy by paying In-Network Providers directly for their services. When you use an In-Network Provider for health care, your provider generally will file claims directly with Empire. For out-of-network claims, send a completed claim form along with an original itemized bill to Empire. The claim form must include the patient's

- name and date of birth.
- member identification number and relation code, which can be found on the member's ID card.

Send completed forms to:

Empire BlueCross BlueShield
Empire Direct POS
PO Box 1407
Church Street Station
New York, NY 10008-1407

Assignment

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

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

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

Tips for Filing a Claim

- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-800-435-1385 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 your Direct POS is the secondary payor, submit the primary payor's Explanation of Medical Benefits (EOB) with your itemized bill. Do not send a photocopy.
- 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, request a duplicate EOB, correct certain claim information and much more at anytime of day or night just by visiting *www.empireblue.com*.

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 maximum allowed amount. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

Tips for Coordinating Benefits

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

If You Receive An Overpayment Of Benefits

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

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

If You Have Questions About a Benefit Payment

Empire reviews each claim for payment purposes to confirm that it is for medically necessary 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 EOB will include:

- The specific reason(s) for any denial or reduction in benefits
- References to the pertinent plan provisions on which the denial or reduction 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 1-800-435-1385 or in writing for more information. When you call, be sure to have your Empire I.D. card number handy, along with any information about your claim.

Send written inquiries to:

Empire BlueCross BlueShield
Direct POS
PO Box 1407
Church Street Station
New York, NY 10008-1407

SUBROGATION AND REIMBURSEMENT

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

Subrogation

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

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

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

Your Duties

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

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

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

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

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

Healthcare 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.**

Reimbursement For Covered Services

Maximum Allowed Amount

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

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

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

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

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

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

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

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

MEMBER COST SHARE

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

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

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

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

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

Example: Your Plan has Coinsurance of 20% for In-Network services, and 30% Out-of-Network after the In- or Out-of-Network Deductible has been met. You undergo a surgical procedure in an In-Network Hospital. The Hospital has

contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

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

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

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

AUTHORIZED SERVICES

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

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

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

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

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

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

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

Your Financial Responsibilities:

As a member of a POS plan, you have certain financial obligations that are your responsibility. For example:

- If your coverage is available through your employer, you may pay a contribution toward your premium.
- You also need to pay providers treating you for any applicable visit fee (co-payment/coinsurance).
- You might have to pay a deductible before certain services are reimbursed.
- In addition, if you choose to have treatment or services provided on an out-of-network basis, in addition to co-payments, coinsurance and/or deductible amounts, you must pay the difference between our payment and the non-participating provider's charge. Check the Your Benefits At A Glance section for details.
- If you choose to receive treatment or services that are not covered, you must pay the cost of these services directly to the provider.
- If you seek services without the required authorization, other than services for an emergency medical condition, you will be responsible for the cost of those services.

Complaints, Appeals and Grievances

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

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

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

STANDARD LEVEL 1 APPEALS

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

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

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

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

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

In addition, if the groups is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Group members have certain rights and protections and the group may have duties as the Group Health Plan Administrator. Among them is the right to appeal a claim decision. Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of

time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

EXPEDITED LEVEL 1 APPEALS

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

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

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

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

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 Hofstra 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, Hofstra will not review it and Empire's decision on the Level 1 appeal will stand. Appeals may be filed by telephone and in writing.

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

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

HOW TO REQUEST AN APPEAL

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

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

Send appeals concerning behavioral health care to:

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

EXTERNAL REVIEW

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

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

A request for a External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.
For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

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

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

Anthem National Accounts
ATTN: Appeals, P.O. Box 5073
Middletown, NY 10940 – 9073

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

COMPLAINTS

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

Empire Member Services
PO Box 1407
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We will resolve complaints within the following time frames:

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

LEVEL 1 GRIEVANCE

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

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

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

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

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

LEVEL 2 GRIEVANCES

If you are dissatisfied with the outcome of your Level 1 Grievance, you may file a Level 2 Grievance with Hofstra. Hofstra 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, Hofstra will not review it and the decision on the Level 1 Grievance will stand. Hofstra 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.

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

- *Pre-service.* Hofstra will complete its review of a pre-service grievance within 15 calendar days of receipt of the grievance.
- *Post-service.* Hofstra will complete its 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 for Level 1 and Hofstra for Level 2 will respond as soon as possible considering the medical circumstances of the case, subject to the following maximum timeframes:

- Empire/Hofstra 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/Hofstra 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 A GRIEVANCE

To submit an appeal or grievance, call Member Services at 1-800-435-1385, 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 a Level 1 appeal or grievance is:

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

The address for filing a Level 2 appeal or grievance is:

Hofstra University
Human Resources
205 Hofstra University
Hempstead, NY 11549-2050

Send appeals concerning behavioral health care to:

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P.O. Box 2100
North Haven, CT 06473

HOW YOU CAN PARTICIPATE IN POLICY DEVELOPMENT

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

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

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

PROVIDER QUALITY ASSURANCE

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

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

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

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 1-800-435-1385.

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

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 notice of specific individual provider affiliations with participating hospitals
- A written description of organizational arrangements and ongoing procedures of the plan's quality assurance program, upon request.
- A written description of procedures followed in making decisions about the experimental/investigational nature of drugs, medical devices, or treatments in clinical trials, upon request.

For Members Who Do Not Speak English

Empire can help members who speak languages other than English to ask questions and file grievances in their first language. When a Member Services representative receives a call from someone who speaks a language other than English, the representative puts the caller on hold and calls the AT&T Language Line. The AT&T Language Line operator links the Member Services representative and the caller to an interpreter in the appropriate language. Through a three-way connection, the interpreter facilitates the inquiry or grievance. Empire's application forms allow members to indicate if their primary language is other than English. Empire tracks this information, and when enrollment of non-English-speaking members reaches a significant level, Empire develops member materials in that language. In addition, the 24/7 NurseLine is equipped to help members in most languages.

Empire's Accommodation of Cultural Needs and Preferences

Empire strives to ensure that our practitioner network and our member materials meet our Direct POS members' cultural needs and preferences. We do this in a variety of ways:

- Empire requests the member's primary language and captures it on our enrollment files. Once a language population becomes a significant portion of our overall membership, member materials are developed and distributed to those members.
- Empire monitors the geographic distribution of its membership who speak languages other than English. When a need for practitioners who speak a certain language in a geographic area is identified, Empire contracts with practitioners, if available, who speak that language. Empire also monitors census data to ensure we address the ethnic needs of our population.
- Printed and web-based network directories include notations of practitioners who speak languages other than English so members who have that preference can readily identify these practitioners.
- Printed and web-based network directories include each practitioner's gender, and Empire regularly assesses the network to ensure there are appropriate numbers of male and female practitioners to accommodate member preferences.
- Member complaints concerning all access-to-care issues, including ones associated with linguistic or cultural needs are closely monitored by Quality Improvement staff to identify network needs or other issues.

Definitions

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

Adverse Determination

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

Ambulatory Surgery

See "same-day surgery."

Authorized Services

See "precertified services."

Co-payment

The fee you pay for office visits and certain covered services when you use in-network providers.

Covered Services

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

Deductible

The dollar amount you must pay each calendar year before your plan pays benefits for covered out-of-network services. Refer to *Your Benefits At A Glance* section for your *deductible* amounts.

Hospital/Facility

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

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

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

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

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

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

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

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

In-Network Benefits

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

In-Network Provider/Supplier

A doctor, other professional provider, or durable medical equipment, home healthcare or home infusion supplier who is in the POS Network.

Itemized Bill

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

Lifetime Maximum

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

Local Network Area

The Local Network Area is the geographic area comprised of 28 counties in eastern New York State (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 and Westchester), and the following Connecticut counties, which are located in the service area of Empire's affiliate, Anthem Blue Cross and Blue Shield, Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.

Maximum Allowed Amount (MAA)

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

Medically Necessary

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

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

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

Non-Participating Hospital/Facility

A hospital or facility that does not have a participation agreement with Empire or another Blue Cross and/or Blue Shield plan to provide services to persons covered under Empire's Direct POS contract.

Out-of-Network Benefits

Reimbursement for covered services provided by Out-of-Network Providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and any amounts above the maximum allowed amount, and therefore, have higher out-of-pocket costs. When you use a BlueCard Program provider, you do not pay any amounts over the maximum allowed amount.

Out-of-Network Providers/Suppliers

A doctor, other professional provider, or durable medical equipment, home healthcare or home infusion supplier who is not in the POS Network.

Outpatient Surgery

See "same-day surgery."

Participating Hospital/Facility

A hospital or facility that is in the POS 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. To identify your Plan Administrator, contact your employer or health plan sponsor.

Precertified Services

Services that must be coordinated and approved by Empire's Medical Management or Behavioral Healthcare Management Programs to be fully covered by your plan. Failure to precertify certain services 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.

Specialty Care Center

This is a facility accredited or designated by a State agency or by a voluntary national health organization having special expertise in treating a specified condition or disease. Examples include, but are not limited to: centers for HIV/AIDS (designated by the New York State AIDS Institute), cerebral palsy (accredited by the New York State Department of Health), cystic fibrosis (designated by the Cystic Fibrosis Foundation), cancer (accredited by the National Cancer Institute, organ transplants (accredited by Medicare), hemophilia (designated by the National Hemophilia Foundation), multiple sclerosis (designated by the National Multiple Sclerosis Society), and sickle cell disease (accredited by the National Institute on Health)/

Treatment Maximums

Maximum number of treatments or visits for certain conditions. Maximums for in-network and out-of-network services are combined.

AudioHealth Library Topics

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

Abdominal Problems

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

Allergies

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

Back and Neck Pain

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

Bone, Muscle and Joint Problems

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

Cancer

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

Chest, Respiratory and Circulatory Problems

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

Chronic Conditions

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

Ear, Nose and Throat

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

Eye Problems

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

First Aid and Emergencies

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

Headaches and Nervous System Problems

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

Home Health Medicines and Supplies

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

Infant and Child Health

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

Infant and Child Health

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

Infectious Diseases

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

Living Healthy

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

Medical Tests and Procedures

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

Men's Health

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

Mental Health Problems and Mind-Body Wellness

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

Partnership with your doctor

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

Senior Health

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

Skin Problems

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

Sleeping Disorders

2400 Sleep Problems
2403 Sleep Apnea
2406 Snoring

Women's Health

1107 Breast Health
1111 Ovarian Cancer
1112 Polycystic Ovary Syndrome
1211 Multiple Pregnancy: Twins or More
1504 Gestational Diabetes
1531 Breast Biopsy
1544 Pelvic Exam and Pap Test
1548 Ultrasound for Normal Pregnancy
2312 Pelvic Inflammatory Disease
2426 Pregnancy, Precautions During
2640 Bacterial Vaginosis
2643 Yeast Infections
2650 Menopause
2651 Hormone Therapy
2670 Missed or Irregular Periods
2672 Endometriosis
2673 Uterine Fibroids
2674 Hysterectomy
2675 Bleeding Between Periods
2677 Functional Ovarian Cysts
2678 Menstrual Cramps
2679 Dsyfuntional Uterine Bleeding
2680 Toxic Shock Syndrome
2700 How to Make a Healthy Baby
2701 Home Pregnancy Test
2704 Danger signs during pregnancy
2705 Normal Pregnancy
2706 Symptoms and Stages of Labor
2708 Diet During Pregnancy
2709 Exercise During Pregnancy
2710 Rubella and Pregnancy
2714 Amniocentesis
2717 Miscarriage
2719 Stretch Marks
2720 Cesarean Section
2723 Pelvic Organ Prolapse
2724 Premenstrual Syndrome
2725 Pregnancy, Symptoms and Stages of
2750 Postpartum Depression

Women's Health

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

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