Welcome!

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

Your Direct HMO, or Health Maintenance Organization, is a network of health care providers available to you from Empire and our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Our "HMO Network" consists of health care providers who have entered into contracts with us or Anthem Blue Cross and Blue Shield to provide services to Empire's members.

As a member, you choose a primary care physician (PCP) from the Direct HMO network. Your PCP will provide basic health care services to you and assist you in coordinating any care you need from other providers. To receive benefits, you need to use In-Network Providers.

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.

What's the Empire Direct HMO Advantage?

When you use Empire Direct HMO network to access health care, you get:

- A comprehensive website, *www.empireblue.com*, for fast, personalized service in a confidential and secure environment.
- One of the largest network of doctors and hospitals in New York State.
- The freedom to self-refer to the network specialist of your choice for covered services.
- Providers that are reviewed for Empire's high standards of quality.
- Minimal out-of-pocket costs for preventive care, behavioral health care and a wide variety of hospital and medical services.
- A PCP to coordinate your care.
- Easy to use – no claim forms to file when you use In-Network Providers.
- Coverage for you and your covered family members when traveling or temporarily living outside of the Local Network Area.

How to Use This Book

You will receive a number of materials that will make it easy to use your plan and understand your benefits:

- Your Direct HMO ID card
- This Handbook, which gives you information about:
  - Finding fast help online
  - Important telephone numbers and addresses
  - How to use your Direct HMO
  - Plan Features
  - How to file a complaint, grievance, or appeal
  - Definitions of select terms
- Your Certificate of Coverage (Certificate), Riders (which are added due to changes in the law, changes in the plan, or due to additional benefits that your group may have purchased) and Schedule of Benefits
- A provider's directory listing all the participating providers in your network, including name, address, telephone number and board certified specialty, if any. It includes a general description of how Empire reimburses each type of provider. The directory and reimbursement descriptions are updated annually.

This benefit book describes how to get needed health care services.

Handbooks are also available on audiotape for the visually impaired. If this applies to you, call Member Services at 1-800-453-0113 to request your audiotape copy.

For definitions of most capitalized terms used in this benefit book, see the Definitions section.

Note: This booklet contains summary information about the Direct HMO program. The Direct HMO 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 HMO program Contract or Certificate and any applicable riders.

The information in this handbook is divided into sections as follows:

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. Please notify us promptly of any address change by calling 1-800-453-0113 or going online at *www.empireblue.com*.

Your Direct HMO Handbook

Introduction

Getting Answers Your Way

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

On the Internet

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

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

By Telephone

WHAT	WHY	WHERE
MEMBER SERVICES	• **For questions about your benefits, claims or membership** • **Select or change your PCP** • **Get information on benefits while traveling**	**1-800-453-0113** TDD FOR THE HEARING IMPAIRED: **1-800-682-8786** 8:30 A.M.TO 5:00 P.M. MONDAY-FRIDAY EMPIRE USES AT&T LANGUAGE LINE FOR TRANSLATION SERVICES FOR OUR MEMBERS WHO DO NOT SPEAK ENGLISH.
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	• **Si usted no habla inglés**	**1-800-453-0113** UN REPRESENTANTE DE SERVICIOS A LOS CLIENTS TE CONECTARA CON UN TRADUCTOR DEL SERVICIOS PARA IDIOMAS EXTRANJEROS QUE HABLA EL IDIOMA APROPIADO. 9:00 A.M. TO 5:00 P.M. DE LUNES - VIERNES
GUEST MEMBERSHIP	• **Get network benefits while you are traveling or temporarily residing outside of the Local Network Area.**	**1-800-453-0113**
BLUECARD® PROGRAM	• **When you need urgent or emergency care outside of the Local Network Area.**	**1-800-810-BLUE (2583)**
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 on health-related topics**	**1-877-TALK-2RN** (825-5276) 24 HOURS A DAY, 7 DAYS A WEEK
EMPIRE'S MEDICAL MANAGEMENT PROGRAM	• **Precertification of out-of-network hospital admissions and certain surgeries, therapies and diagnostic tests (your Network Providers will call to precertify in-network benefits)**	**1-800-441-2411** 8:30 A.M. TO 5:00 P.M., MONDAY-FRIDAY
BEHAVIORAL HEALTH CARE MANAGEMENT	• **Precertification of mental health and alcohol/substance abuse care**	**1-800-453-0113** NON-EMERGENCY CARE 8:30 A.M. TO 5:00 P.M. MONDAY-FRIDAY EMERGENCY CARE, 24 HOURS A DAY 7 DAYS A WEEK
MATERNITY CARE PROGRAM	• **Get information about pregnancy** • **Identify resources for high-risk pregnancies**	**1-800-845-4742** 8:30 A.M. TO 5:00 P.M. MONDAY-FRIDAY

WHAT	WHY	WHERE
EMPIRE PHARMACY MANAGEMENT PROGRAM℠	• **Information about the program and procedures, or to locate a participating retail pharmacy** • **Obtain a complete drug formulary list**	**RETAIL: 1-800-453-0113** TDD FOR HEARING IMPAIRED: **1-800-241-6895** 7:00 A.M. TO 10:00 P.M. MONDAY-FRIDAY 9:00 A.M. TO 9:00 P.M. SATURDAY 9:00 A.M. TO 5:30 P.M. SUNDAY
VISION CARE	• **To find a participating vision care provider in your area**	**1-800-453-0113** 8:30A.M. TO 5:00 P.M. MONDAY-FRIDAY 9:00 A.M. TO 4:00 P.M. SATURDAY
DENTAL CARE	• **For questions about your benefits and claims**	**1-800-722-8879** 8:00A.M. TO 8:00 P.M. MONDAY-FRIDAY 9:00 A.M. TO 1:00 P.M. SATURDAY
FRAUD HOTLINE	• **Help prevent health insurance fraud**	**1-800-I-C-FRAUD (423-7283)** 9:00A.M. TO 5:00 P.M. MONDAY-FRIDAY
NEW YORK STATE DEPARTMENT OF HEALTH COMPLAINT HOTLINE	• **To file a complaint with the New York State Department of Health**	**1-800-206-8125** 9:00 A.M. TO 4:30 P.M. MONDAY-FRIDAY

In Writing

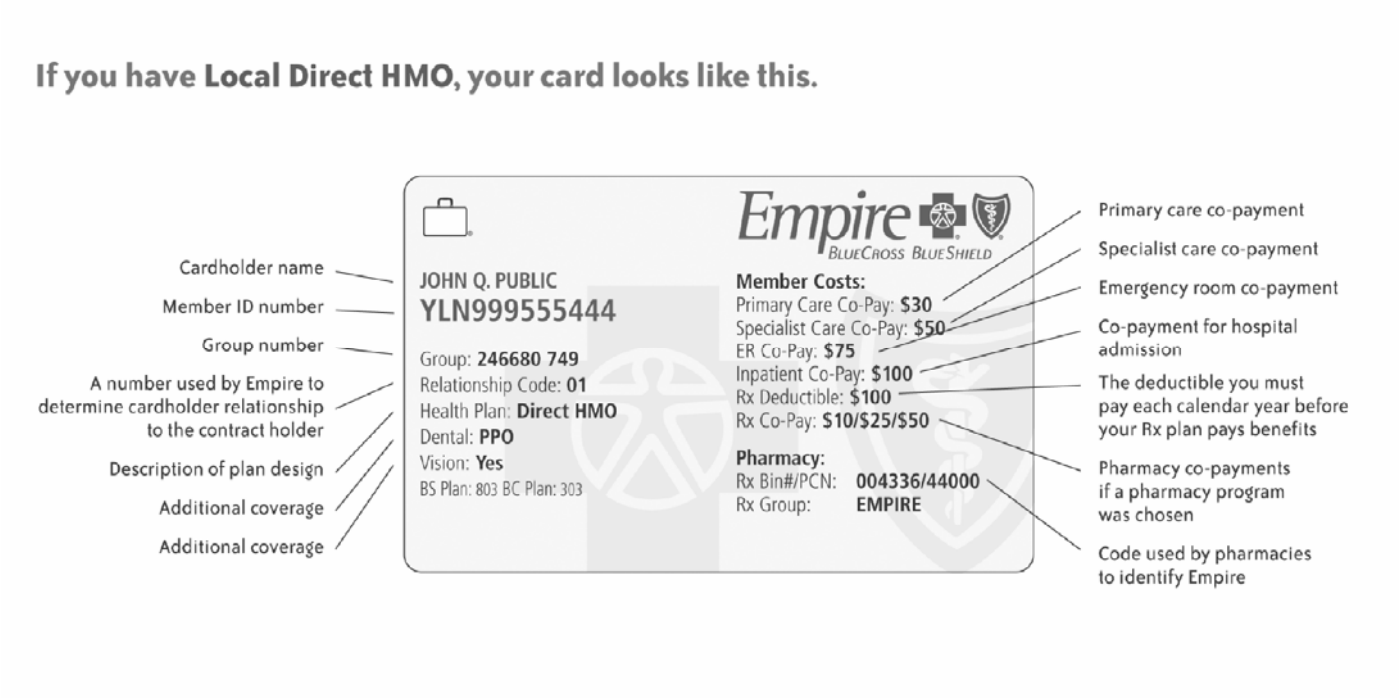
Empire BlueCross BlueShield
Direct HMO Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

(For dental inquiries, use the address in the “Dental Care” section of this handbook.)

Your Identification Card

Empire wants to make accessing your health care easy. The Empire ID card is a single card that you can use for all your Empire health maintenance organizations services as it shows each of the health plans or programs you're enrolled in. Always carry it and show it each time you receive health care services. Every covered member of your family will get his/her own card.

The information on your card includes your name, your identification number, your co-payment amounts for medical visits, and the types of coverage, included in your plan.



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

Q: Why is Empire's ID card so helpful?

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

Q: Why does each family member get a separate ID card?

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

Q: I lost my ID 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.

Q: My PCP's name is not on the card. Do I still have to go to my PCP for routine care?

A: Yes. Even though your PCP's name is not on the identification card he or she is still the person who is responsible for your routine health care needs. However, for specialized services you may still self-refer to the network specialist of your choice.

Q: What if someone in my family forgets the name of his or her PCP?

A: He or she can call Member Services or look up the name online at *www.empireblue.com*.

Q: Where can I get additional information?

A: Visit *www.empireblue.com* or call Member Services, whichever is more convenient for you.

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, gynecologist or chiropractor and the second co-payment is for specialists (SPEC).

Using Your Direct HMO

Your PCP

The Empire Direct HMO 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 see your PCP. Your PCP will:

- Provide basic and preventive care such as routine checkups and screening tests
- Help you select a network specialist, although you may self-refer
- 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, physical therapy

You and each covered family member must select a PCP when you enroll. Family members can share your PCP or select their own. A PCP can be an internist, general or family practitioner, or a pediatrician (for children). If you do not select a PCP, Empire will assign one to you upon initial enrollment.

Take time to choose your PCP. As a member of Empire's Direct HMO, 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). To locate an In-Network Provider, visit *www.empireblue*.com and click on "*Local Area Provider*". 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 1-800-453-0113 to request that a Provider Directory be mailed to you free of charge.

Tips for Selecting a PCP

- For a comprehensive provider listing 24 hours a day, 7 days a week, visit *www.empireblue.com*. Call Member Services at 1-800-453-0113 to confirm that the doctor you selected is a PCP or check the box in our on-line directory to select doctors that can serve as your PCP. 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? Evenings? Saturdays? Does the doctor fit your preference for male or female? 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, call for an initial appointment so your PCP can know you and your medical situation before an urgent situation occurs.
- You will need your ID card and should be prepared to spend a little extra time to complete the initial patient forms. Can't find your ID card? Print a temporary card at *www.empireblue.com* or call Member Services.

Changing Your PCP

You can change your PCP at any time by visiting *www.empireblue.com* or calling Member Services at 1-800-453-0113. Changes are generally effective immediately.

High Marks for Provider Quality

Whichever network PCP or specialist you choose from the HMO Network, you can be assured that they meet the high 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 HMO 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 — immediately
  - Initial newborn care — within two weeks
  - Routine follow-up care — within two weeks
- See patients promptly when they have a scheduled appointment.
- Have 24-hour network physician backup (for PCPs).
- Meet appropriate professional and ethical standards.

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).

Learn More About Empire Network Doctors

You can get information on the professional qualifications of our In-Network Providers by calling Member Services at 1-800-453-0113, or by visiting *www.empireblue.com* or the American Medical Association's website *www.ama-assn.org/aps/amalg.htm*.

Continuity of Care

If a Provider Leaves the Network

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

Additionally, Empire will help you to find another In-Network Provider. 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, and services are authorized by Empire's Medical Management program. 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.

If You are a New Member

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, with a provider not participating with Empire, following the enrollment date. Members who are pregnant, and in their 2nd or 3rd trimester on the effective date of coverage may continue care with a provider not participating with Empire, 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. You must contact our Medical Management department to arrange this continued care.

Quality Care/ Lower Costs

Empire takes special care in selecting In-Network Providers. When you use the HMO network, you pay less too. To get the network advantage, you must visit network specialists or other In-Network Providers for most covered services. A referral is not needed. When you visit a In-Network Provider, you will pay a small co-payment. Empire will give claim information to your PCP about each of your specialist visits.

Need to See a Specialist?

Your Direct HMO allows you to self-refer to any network specialist of your choice. To locate a network specialist, check your Provider Directory or visit *www.empireblue.com.* You may also call Member Services for help in locating a specialist or to confirm that the specialist you have chosen is an active HMO 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 problem. You are not required to ask your PCP for help or permission — the choice is yours and you may change your specialist at anytime.

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, your SCC receives 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 Dept. 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)
- 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 "Your 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.

Tips for Visiting a Specialist

- Be sure to visit a network specialist
- 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 a 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.

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 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, you 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 Empire Direct HMO Benefits Out-of-Area

When you need health care services outside of the Local Network Area, you are eligible for the Guest Membership and BlueCard® Programs.

Guest Membership

When you are outside of the Local Network Area for business, vacation or school, Guest Membership offers temporary coverage through a local Blue Cross and/or Blue Shield HMO plan and its network of participating providers. You are eligible for a Guest Membership if you are away from home for:

- More than 90 days but less than 180 days and you are a subscriber or retiree, or
- More than 90 days and you are a student or covered dependent.

Call Member Services for more information and enrollment in Guest Membership.

With your Guest Membership:

- You do not have prescription drug coverage. If you are covered through the Empire Pharmacy Management Program (see the "Empire Pharmacy Management" section), you may be eligible for coverage while you are away from home. Call the pharmacy program for details.
- You may be able to receive mental health or alcohol/substance abuse coverage through Empire's Behavioral Health Care Program. Call 1-800-453-0113. If there are no participating mental health care providers in your area, you may still be able to receive benefits. Contact Members Services for more information.

BlueCard® Program

If you are not enrolled as a guest member, but require out-of-area urgent or emergency care within or outside the United States, coverage is available through the BlueCard Program (see the definitions section for more information regarding the BlueCard Program). See the "Emergency and Urgent Care" section for more information on urgent or emergency care or call Member Services at 1-800-453-0113 for details. You may also visit the Blue Cross and Blue Shield Association's website at *www.bcbs.com* for more information.

Where to Find Information on Your Benefits

Information on Your Benefits

Your Certificate of Coverage (Certificate), Schedule of Benefits and Riders (added due to changes in the law, changes in the plan, or due to additional benefits that your group may have purchased) give you detailed information on the broad range of services and benefits that your Direct HMO offers you and your family. Be sure to look at these documents so you understand what the plan covers, and any requirements, restrictions or limitations. They contain the complete terms of your coverage.

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

Certificate of Coverage

Your Certificate is the legal document that determines your Direct HMO coverage. In your Certificate, you will find information such as:

- Detailed descriptions of covered services
- Conditions that must be met before certain services will be covered
- Limitations on certain benefits, such as the number of visits or days of care the plan will cover
- Exclusions
- Coverage limits if you have a pre-existing condition
- The rules for Coordination of Benefits (COB) when you are covered by more than one plan
- Continuing your coverage when it terminates
- Other plan provisions

Riders

This Certificate may have Riders describing additional benefits that were added due to changes in the law, changes in the plan, or due to additional benefits that your group may have purchased, such as prescription drug or vision care coverage. Some plans may have more than one Rider, or may have no Riders.

Schedule of Benefits

The Schedule of Benefits will give you more details on your benefits including:

- Ages to which dependent children are covered
- Co-payments, coinsurance and other cost-sharing amounts
- Any limits on the number of visits or days of care for certain covered services
- Other limitations and exclusions

Features and Benefits

Coverage

This section of the handbook summarizes the benefits and features of your Empire Direct HMO coverage. However, the full legal description of these benefits and features is contained in the Certificate, Riders and Schedule of Benefits. If anything in this handbook conflicts with any of the terms contained in those legal documents, the terms of the Certificate, Riders and Schedule of Benefits will govern.

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.

Hospitals, Other Facilities and Same Day Surgery

Your Empire Direct HMO covers most or all of the cost of your care when you stay in a network hospital or other network facility for surgery or the treatment of illness or injury. This includes care in a network skilled nursing facility, or birthing, dialysis, rehabilitation and other centers. See the "Details and Definitions" section, or refer to your Certificate for a description of covered facilities.

Your PCP or network physician must precertify all non-emergency hospital admissions, surgery, specialized ambulatory surgery and admissions to a skilled nursing facility or other facility with Empire's Medical Management Program at least two weeks prior to any planned surgery or hospital admission. Empire's Medical Management Program reviews the medical necessity for care and the appropriateness of the setting. See the "Health Management" section and your Certificate for services requiring Medical Management precertification.

All hospital admissions and surgery must be:

- Medically necessary and appropriate
- In-network (except in an emergency or when your PCP and Empire's Medical Management Program decide that care outside the network is more appropriate)
- Precertified with Empire's Medical Management Program. In an emergency, your PCP must notify Medical Management within 48 hours of the admission, or as soon as reasonably possible
- Coordinated by your PCP or other In-Network Provider (unless Empire's Medical Management Program approves care from a non-network provider)

Tips for Scheduling Same-Day Surgery

- If you are having outpatient 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 your surgery.
- Ask your doctor for any needed prescriptions before the day of your scheduled surgery. Filling your prescriptions in advance will give you one less thing to worry about afterwards. (See the "Empire Pharmacy Management" section.)

Second Surgical Opinions

If your PCP or specialist recommends surgery, you may get a second or third opinion from an appropriate network specialist. No co-payment is required. The specialist giving the second or third opinion cannot perform the surgery.

Second Medical Opinions for Cancer

You may visit any appropriate specialist for a second medical opinion to clarify a cancer diagnosis or a recurrence of cancer. You may also request a second opinion regarding any recommended course of treatment for cancer. The specialist giving the second opinion may include a network specialist with a Specialty Care Center for the treatment of cancer. You must receive the approval of Empire's Medical Management Program before visiting a non-network specialist. If Empire approves the visit to a non-network specialist, there's no additional cost to you.

Breast Cancer Surgery

The patient has the right to decide, in consultation with the physician, the length of hospital stay following lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer. However, the actual admission must be precertified by Empire's Medical Management Program.

Exclusions/Services Not Covered

Here are some examples of services that are not covered:

- Private duty nursing
- Private room (unless medically necessary)
- Non-medical items, for example television rental or telephone charges
- Hospital admissions where the admitting physician is not in the network, unless preapproved by Empire's Medical Management program
- Investigational or experimental treatments
- Cosmetic surgery
- Certain fertility treatments
- Skilled nursing facility that primarily:
  - Gives assistance with daily living activities
  - Is for rest or for the aged
  - Treats drug addiction or alcoholism
- Custodial care

Please see your Certificate for a complete list.

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.

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).

Laboratory Services

Empire contracts with Quest Diagnostics, Inc. and with certain hospital and specialty laboratories to provide outpatient laboratory services, as described in our provider directory. You must have outpatient laboratory services performed by a participating laboratory in order to receive coverage. Empire HMO plans do not cover these services when rendered by non-participating laboratories. Visit our website at *www.empireblue.com* or call Member Services at 1-800-453-0113 for the most up-to-date information about participating laboratories.

Preventive Care

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

- Routine physical exams (checkups) from your PCP
- Well-Child care from your child's PCP
- Mammography screening
- Pap Smears
- Diagnostic screening for prostate cancer

Empire routinely distributes information on nationally accepted standards of clinical care to network physicians — helping your doctor to deliver quality health care to you and your family.

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

Tips for Using Preventive Care

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations

To view the most up-to-date preventive care guidelines for adults and children, visit the "Health Education" section of "About Empire" at *www.empireblue.com.* The following chart outlines some of the many preventive care services and screenings that your Direct HMO provides. See your Certificate for a complete listing.

PREVENTIVE CARE AND SCREENINGS
Routine Physical Examination
Prostate Specific Antigen (PSA) Screening — (for men)
Well-Woman Care • Office Visits • Two pelvic exams annually -Pap Smears -Cervical Cancer evaluation • Follow-up treatment of acute gynecological conditions • Mammogram -Ages 35 through 39: 1 baseline -Ages 40 and older: 1 per year -Upon recommendation by a physician, a mammogram at any age for covered persons having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer • Bone Density Screening (if you meet certain criteria) • Maternity care including the Maternity Care Program
Well-Child Care from your child's PCP • 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 to 1st birthday: 7 visits – Ages 1 through 4 years of age: 6 visits – Ages 5 through 11 years of age: 7 visits – Ages 12 up to 17 years of age: 6 visits – Ages 18 to 19th birthday: 2 visits • Lab tests • Immunizations (office visits are not required) • Lead screenings

Emergency and Urgent Care

If You Need Emergency Care

Should you need emergency care, Empire's Direct HMO is there to cover you. Emergency care is covered in the hospital emergency room, urgent care center or your physician's office. Urgent care is covered in an urgent care center or in your physician's office. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

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

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 HMO 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 or urgent care facility. The emergency room co-payment is waived if you are admitted to the hospital within 24 hours for a condition related to the emergency. If you make an emergency visit to your PCP's office, you pay the office visit co-payment. See your Schedule of Benefits for co-payment amounts.

REMEMBER:
You will need to show your identification card when you arrive at the emergency room.

If you are admitted to the hospital, you or your representative need to call your PCP within 48 hours or as soon as is reasonably possible so that your PCP can call Empire's Medical Management Program. Your PCP or other network physician must provide all follow-up care.

Tips for Getting Emergency Care

- You do not need to have your physician's approval for emergency care. If time permits, call your physician to direct you to the best place for treatment.
- If you have an emergency while outside the Direct HMO service area anywhere in the United States, follow the same steps described above. If the hospital participates with another Blue Cross and/or Blue Shield plan, your claim will be processed by the local Blue Cross and/or Blue Shield plan. Be sure to show your Empire identification card at the emergency room, and if you are admitted, notify your PCP within 48 hours of admission. If the provider 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 the United States, and are admitted to a hospital, simply show your Empire ID card. If the hospital participates in the BlueCard Worldwide Program, it will submit the claim to us. If the hospital does not participate in the BlueCard Worldwide Program, or if you are not admitted to the hospital, you will need to pay the bill at the time of treatment and file a claim with us. Please call Member Services for the names of participating doctors and hospitals. You may refer to the Definitions section in the back of this benefit book for more information on this special program.

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)

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. If you 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, 7 days a week so you have access to urgent care. You can also call 24/7 NurseLine for advice from registered nurses at 1-877-TALK2RN (825-5276) 24 hours a day, 7 days a week.

Tips for Getting Urgent Care

Within the Local Network Area :

- If you visit an emergency room or urgent care facility, you or your representative should call your PCP within 24 hours of seeking care or as soon as reasonably possible. Your PCP or other network physician must provide all follow-up care.

Outside the Local Network Area :

- If you are going to be outside the Local Network Area, and know that you may need urgent care, obtain instructions from your own physician prior to arranging for a visit with a BlueCard provider.
- If you are inside the United States call your PCP for advice. You can also call member services to obtain names and locations of BlueCard participating providers. Show your ID card when you go to the doctor's office and pay the office co-payment indicated on your card. There are no claim forms to file and you do not need a referral.
- If you are outside of the United States and receive urgent care from a doctor in the BlueCard Worldwide Program, pay your bill at the time of treatment. Submit an international claim form to Empire for reimbursement.

You can call 24/7 NurseLine at 1-877-TALK-2RN (825-5276), 24 hours a day, 7 days a week to talk to professional nurses who can give you medical information.

Behavioral Health Care

If You Need Behavioral Health Care

At Empire we realize that your mental health is as important as your physical health. That's why we include behavioral health benefits. Your behavioral health care benefits cover inpatient and outpatient mental health care and treatment for alcoholism or substance abuse. See your Certificate, Schedule of Benefits and Riders for specific information, including limits on the number of visits or days of care and co-payment amounts.

BEHAVIORAL HEALTH CARE	
MENTAL HEALTH CARE OR ALCOHOL/SUBSTANCE ABUSE TREATMENT (includes crisis intervention)	
• Outpatient (individual, group, day treatment programs)	Co-payment per visit
• Inpatient	$0

For the Behavioral Health Care Management Program, call 1-800-453-0113 weekdays, between 8:30 a.m. and 5:00 p.m., for advance approvals, referrals and answers to questions. For emergencies, the program is available 24 hours a day, seven days a week at the same toll-free number.

Tips for Arranging Your Behavioral Health Care

- When you call the Behavioral Health Care Management Program, a patient care coordinator will refer you to a program or provider that best meets your needs. If you need help immediately, a clinical care manager will assist. All contacts are kept strictly confidential.
- When you are admitted in an emergency to a hospital or other inpatient facility, you or someone on your behalf must call the Behavioral Health Care Management Program within 48 hours or as soon as is reasonably possible.
- If you do not follow the requirements of the Behavioral Health Care Management Program, you will need to pay for the full cost of your care.
- If you disagree with a Behavioral Health Care Management Program decision, you may appeal. See the "Complaints, Appeals and Grievances" section for information.

Services Not Covered

These Behavioral Health Care services are not covered:

- Services not preapproved by the Behavioral Health Care Management Program, with the exception of the first 12 routine outpatient visits per provider per calendar year.
- Services beyond those stated in your Certificate, Schedule of Benefits and Riders

Empire Pharmacy Management

Not all plans have pharmacy benefits. Check your Certificate, Schedule of Benefits and Riders to see if you have this coverage.

Empire understands that prescription drugs can be costly. To help reduce your costs, Empire offers the Pharmacy Management Program.

Filling a Prescription

The prescription drug plan covers most drugs that have been approved by the Food and Drug Administration (FDA) if the drugs are medically necessary for the treatment of the condition for which they are prescribed, and for which you have a prescription from your physician or other licensed provider. To receive the benefits of your pharmacy program, you must fill your prescription at a network pharmacy or through the mail-service program.

You pay a co-payment and/or a deductible each time you fill your prescription, whether at a network pharmacy or through the mail-service program. Co-payments may vary depending on the type of prescription drug coverage you have and whether the prescription is for a generic, brand-name formulary or non-formulary drug. Using generic medicines, where appropriate, will help you to maximize your benefits. In some cases, use of generic medicines may be required under the terms of your pharmacy rider. See your Certificate, Schedule of Benefits and Riders for details on your pharmacy benefits, limitations, exclusions, deductibles and/or co-payments.

Empire's Drug Formulary

Empire's Drug Formulary is a list of covered prescription drugs recommended for use by Empire's providers. It includes generic and certain covered brand-name drugs. Depending on the type of prescription drug coverage you have, you may have to pay a higher co-payment for brand-name formulary and non-formulary drugs, and realize the most savings for generic drugs.

Pharmacists and actively practicing doctors identify prescription drugs to include in the formulary. The selections, based on sound clinical evidence, were evaluated for safety, quality and effectiveness. You can get an up-to-date formulary by visiting *www.empireblue.com* or calling Member Services at 1-800-453-0113. Member Services can also provide information about Empire's procedures and pharmaceutical decisions.

Some drugs must be specially ordered. In order for certain specialty injectable medications to be covered under Empire's pharmacy plan, prescriptions must be filled by PrecisionRx Specialty Solutions, our exclusive vendor for specialty injectable drugs. Some specialty injectable drugs are listed in the formulary. Those particular medications indicate the symbol SRx next to them. A complete list of specialty injectable drugs can be found by going to the "Pharmacy" section at *www.empireblue.com***.** For further information regarding filling a prescription for specialty injectable medications call 1-800-453-0113.

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

Prior Authorization

Certain drugs require prior authorization. They are identified as "PAR" (Prior Authorization Required) and must be approved by Empire before coverage can be offered for the prescription to be filled. To find out which drugs require prior authorization, your physician or pharmacist can request this authorization by calling Empire Pharmacy Management at 1-800-453-0113. If the drug is approved, it will be covered.

Quantity Limits

Some drugs have quantity limits. They are indicated by the letters "QL" (Quantity Limit) and require authorization only if a prescription is written for more than the monthly Allowed Amount. Your physician or pharmacist can request this authorization by calling Empire Pharmacy Services at the Member Services telephone number listed on the back of your Member ID card. If the quantity is approved, it will be covered.

Empire Pharmacy Management Customer Service: 1-800-453-0113

Network Pharmacy

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

- Low cost. You can receive up to a 30-day supply for each drug for a single co-payment.
- Convenience. Just present your Empire ID card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program.
- No claim forms! Your claim is submitted by the pharmacist when you fill the prescription.

Tips for Using a Network Pharmacy:

To locate a network pharmacy, check the list of national chain pharmacies you received with your ID card. For information about all network pharmacies go to our website *www.empireblue.com* or call Empire Pharmacy Management at 1-800-453-0113. You can also call when you are away from home for the name and location of a participating network pharmacy within that area.

Save Money, up to 33%, with Empire's Mail-Service for Prescriptions

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

The same prescriptions filled at a participating pharmacy costs three co-payments for a three-month supply of medication—one co-payment for each 30-day supply. In addition, Empire waives drug deductibles (if applicable) when you use the mail-service. Deductibles (if applicable) still apply if you fill your prescriptions at a pharmacy.

How to Order your Prescriptions by Mail

1. If you need to take a drug on a long term basis, ask your doctor to write a prescription for each of your medication(s) that covers a 90-day supply as well as three refills. (Example: If you take 2 pills per day, the prescription should be written for 180 pills plus three refills.)
2. Complete the mail-service form you received in the mail with your ID card(s). You can get additional forms by going to *www.empireblue.com* or calling Empire Pharmacy Management at the number on the back of your member ID card.
3. Place your order for a refill at least three weeks before your current supply will run out.

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

Vision Care

If your group has vision care coverage, please refer to your Certificate of Coverage and/or Vision Care Rider, and your Schedule of Benefits for information regarding your vision benefits and cost sharing.

To find a participating provider in your area, simply call 1-800-453-0113 between 8:30 a.m. to 5:00 p.m. EST Monday through Friday. You can also visit *www.empireblue.com* to locate a provider.

Vision Care questions? Check "About Empire" and "Plans and Services" sections at *www.empireblue.com*.

Dental Care

If You Need Dental Care

If your employer/plan sponsor has purchased dental coverage, your Contract or Certificate will have a Rider with detailed information about the basic and major dental care covered, co-payments and annual maximums and deductible requirements. Annual or lifetime maximums for most of Empire's plans allow predictable costs and keep benefits affordable for care that is most essential. After coverage of in-network diagnostic and preventive care — the cornerstone of good oral health — Empire shares a percentage of cost with you on other necessary dental benefits.

To ensure providers meet our very high service standards, we screen all dentists before accepting them into our network. You can be assured that the dentist you choose is required to:

- Be conveniently located.
- Offer clean and efficient service.
- Make appointments available for new subscribers.
- Provide adequate staffing and equipment.
- Maintain 24-hour arrangements should you or your dependents need after-hour dental care.

Empire offers a range of dental products and networks to meet a variety of needs. No matter which plan you have, you'll enjoy a wide choice of providers, friendly, efficient customer service and a focus on prevention to help you keep your healthy smile for a lifetime.

Refer to your Dental Rider for further information regarding the Dental Coverage that you have purchased.

How to Nominate a Dentist to our Network

If your current dentist is not part of Empire's dental network and you are comfortable with the care you are receiving, you may nominate him for inclusion in Empire's Dental network. Simply fill out the postcard that's enclosed at the front of your provider directory and mail the completed card to Empire. However, if you continue to use your dentist and he is an Out-of-Network Provider, you will be subject to higher out-of-pocket costs.

For more information check: "About Empire" and "Plan and Services" at *www.empireblue.com* or call Dental Customer Service at 1-800-722-8879.

How to Submit Dental Claims

Submit claims forms to:

Empire BlueCross BlueShield
Empire Dental Benefits Program
PO Box 791
Minneapolis, MN 55440-0791

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.

In most situations, network physicians, hospitals, outpatient facilities, vendors and other In-Network Providers are responsible for calling Empire's Medical Management Program to precertify certain services covered by the plan.

Empire's Medical Management Program works with 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 directly by calling 1-800-441-2411.

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.

REMEMBER:

It is the responsibility of the In-Network Provider to precertify certain services covered by the plan.

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

PROVIDER WILL CALL TO PRECERTIFY…
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 • If the mother or newborn remains hospitalized more than two days after a vaginal delivery or more than four days following a cesarean section
PREGNANCY • Within the first three months of a pregnancy
BEFORE YOU RECEIVE/USE • Outpatient occupational, physical and speech therapy • Specialized ambulatory surgery - Medically necessary cosmetic/reconstructive procedures - Outpatient transplants - Ophthalmological or eye-related procedures • A magnetic resonance imaging or magnetic resonance angiography scan (MRIs or MRAs), PET Scans, CAT Scans and Nuclear Cardiology • Durable medical equipment, prosthetics, orthotics • Non-network care (available under certain conditions) • Chiropractic care*

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

If Services Are Not Precertified

If your In-Network Provider does not precertify the services listed above, Empire will not cover them. However, the In-Network Provider may not bill you. Should you receive a bill, please call Member Services at 1-800-453-0113. If you use non-network providers, you are responsible for the full charge for services unless you have prior approval from Empire.

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 your PCP or a network specialist must contact Empire's Medical Management Program 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 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. 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.

Medical Advances and Your Health Plan:

Nearly every day, the media reports stories on new devices, medications, and medical procedures. That's not surprising when you consider that the medical, behavioral, and pharmaceutical health fields constantly change. Empire stays informed about medical advances and, when appropriate, creates or updates certain policies to address these new technologies. In addition, our medical, behavioral, and pharmaceutical policies—which specify services covered and under what circumstances—are evaluated and reviewed periodically by teams of health care professionals who base their opinions on recent medical literature and scientific data. Examples of materials that may be reviewed when making medical, behavioral, and pharmaceutical policy decisions on new medications, devices, and procedures are:

- Peer-reviewed, professional medical publications and journals.
- The policies/procedures of government agencies (the Food and Drug administration and the National Cancer Institute).
- Credible results indicating the positive impact the medical technology has on long-term health.
- The opinions of physicians, specialists, and other health care consultants.

Commitment to Quality Care

Empire's Medical Management Program is run by a team of qualified clinical personnel, who reviews ongoing care and looks at care retrospectively, in addition to precertifiying care. When your provider contacts Empire's Medical Management Program to ask for preapproval for medical services, Empire's Medical Management team reviews the request, and discusses it with your provider. When making a decision, Empire's Medical Management Program considers:

- Are the medical care and services appropriate?
- What are the qualifications of the providers giving the care?
- Is the setting — inpatient, outpatient, facility, etc. — in which the services will be delivered appropriate?

Empire BlueCross BlueShield is committed to providing access for the delivery of quality medical care and services to its members. Those in Medical Management share this commitment by:

- Making utilization management decisions based only on the appropriateness of care and service, existence of coverage, the provider of these services, and the setting in which the services will be delivered.
- Having no specific rewards in place to encourage case managers, medical directors, outside consultants and other Empire employees who perform medical management functions to deny coverage for medical care and services.
- Taking steps to guard against the inappropriate restriction of care by specifically acknowledging the risk of underutilization that can result from overly aggressive utilization management decisions.
- Having no financial incentives to encourage decisions that could result in underutilization.

If a Request Is Denied

All denials of benefits will be rendered by qualified medical personnel. If a request for care or services is denied for lack of medical necessity, or because the service has been determined to be experimental or investigational, Empire's Medical Management Program will send a notice to you and your doctor with the reasons for the denial. You will have the right to appeal. (See section in this 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 Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Retrospective Reviews

Once a covered service has been pre-authorized, we will not reverse our medical necessity decision unless all of the following circumstances are present:

- Relevant medical information presented upon retrospective review is materially different from the information presenting during pre-authorization;
- The information existed at the time of pre-authorization but was not made available;
- Empire, or its delegate was not aware of the existence of the information at the time of pre-authorization, and
- The treatment, service or procedure would not have been authorized if the information were available at the time of pre-authorization.

Time Frames for Response

Empire's Medical Management Program will respond to a request for coverage by telephone and/or in writing within the following time frames.

WHEN YOU REQUEST	A RESPONSE WILL BE SENT
• **Precertification of care or services.**	• **Within three (3) business days of receiving the necessary information but not to exceed 15 calendar days from the receipt of the request.**
• **Approval if you are already hospitalized or in a course of treatment.** • **Review of a decision in cases where denial of precertification or continued approval of an ongoing course of treatment was not discussed with your provider.**	• **We will make a decision within 24 hours of receiving the request and will provide a response by phone and in writing within one business day of making the decision.**
• **A review after care was provided.**	• **Within 30 days of the request.**

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.

Details and Definitions

Eligibility

At Empire we recognize that families grow and change, so we want you to be aware of how these changes impact your health care coverage.

When Are You Eligible?

Your coverage under your Direct HMO 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 Group Benefits Administrator for more information on eligibility rules.

NEWBORN ENROLLMENT

Individual, Employee/Spouse

Members with individual or employee/spouse coverage must submit an Enrollment/Change form to add the newborn and switch to family or parent/child coverage within sixty (60) days after the date of birth for coverage for the newborn to be retroactive to the date of birth. Otherwise, family coverage will begin on the date that we receive and accept from your group the member enrollment form, during the next open enrollment period after the birth or the first year after the birth, whichever occurs first.

Family and Parent/Children

A member who has family or parent/children coverage has coverage for his/her newborn child, but MUST submit an Enrollment/Change form to add his/her newborn to the benefit contract within (60) sixty days from the date of birth. Coverage is effective from the date of birth for a newborn.

Note: Eligibility is subject to all terms of your benefit Contract or Certificate of Coverage. These enrollment requirements are applicable to children as defined in the Contract or Certificate of Coverage, including newborns who are adopted or proposed to be adopted by the member. Once the newborn is enrolled, Coordination of Benefits (COB) rules apply.

Adding and Removing Dependents

- Spousal coverage ends on the last day of the month following a divorce or annulment.
- Dependent children with certain forms of mental illness, developmental disabilities, mental retardation or a physical handicap may be covered beyond the customary age limit. Call Member Services to request an application for your dependent's physician to complete. Our Medical Staff will review the application. If approved, your dependent will be continued under your family coverage.
- Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.

Qualified Medical Child Support Order (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 the group health plan participant.

Continuation of Coverage

For more details on eligibility (including Medicare), termination, continuing coverage for yourself or dependents and conversion of coverage, check your Certificates and any applicable Riders. You can also call Member Services for more information on continuation of coverage. If you are no longer eligible for group Direct HMO coverage because your employment ends or you become a part-time employee, you may also call Direct Payment Member Services at 1-800-261-5962 for assistance.

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.

REMEMBER:

New Dependents will need a PCP. See Tips for Selecting a PCP in the "Your PCP" section.

The Veterans Benefits Improvement Act of 2004

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

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

Reservists Supplementary Continuation and Conversion

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

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

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

Subrogation

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

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

Duty to Cooperate with Us – Possible Penalties for Failure to Cooperate

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

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

Portability of Coverage

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

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 1-800-453-0113.

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.

Filing a Claim

If You Need to File a Claim

Your Empire Direct HMO makes health care easy by paying In-Network Providers directly for their services. When you use your Direct HMO for health care, your In-Network Provider, generally will file claims directly with Empire. In the rare instance that you receive a bill, send a completed claim form along with an 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 HMO
PO Box 1407
Church Street Station
New York, NY 10008-1407

Tips for Filing a Claim

- Visit *www.empireblue.com* to print out a claim form immediately or contact Member Services at 1-800-453-0113 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 HMO plan is the secondary payor (see the "Coordination of Benefits" section), 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 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 1-800-453-0113 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 HMO Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

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.

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 an HMO 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). This is usually payable at the time the services are rendered.
- You might also have to pay a deductible before certain services are reimbursed. Check your Schedule of benefits 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 out-of-network services without the required authorization, other than services for an emergency medical condition, you will be responsible for the cost of those services.

Patient's Self-Determination Act

Under New York law, you have the right to:

- Make medical decisions.
- Accept or refuse treatment, including the right to refuse life-sustaining medical and surgical treatment.
- Make advance directives about your medical care in the event that you cannot make decisions. See the "Definitions" section for an explanation of "Advance Directives."
- Learn more about your Member Rights and Responsibilities by calling Member Services at 1-800-453-0113.

Member Services

You may visit *www.empireblue.com* or call Member Services at 1-800-453-0113 for claim and benefit information. You can also go online or call to receive the following information:

- 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 sample of Empire's direct payment contracts
- A consumer report of grievances filed with the Insurance Superintendent
- Procedures that protect confidentiality of medical records and information
- A notice of specific individual provider affiliations with participating hospitals
- A description of the network contracting procedures and minimum requirements for In-Network Providers
- 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.

If you prefer, you may write to us at:

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

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 BlueCross BlueShield
HMO 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.

Health Care Fraud

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

FRAUD HOTLINE:
1-800-I.C. FRAUD (423-7283)
9:00 a.m. to 5:00 p.m.
Monday – Friday

Complaints, Appeals and Grievances

COMPLAINTS

A complaint is a verbal or written statement of dissatisfaction where Empire is not being asked to review and overturn a previous determination. For example: You feel you waited too long for an answer to your letter to Empire. If you have a complaint about any of the 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 BlueCross BlueShield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
Attention: Member Services

If your complaint concerns behavioral health care, call 1-800-453-0113 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

We will resolve complaints within the following time frames:

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

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

You may also call the New York State Department of Health Complaint hotline at any time, for any reason at 1-800-206-8125, or write to:

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

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 Right to Appoint a Representative

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

STANDARD INTERNAL APPEALS

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

Appeals may be filed by telephone or in writing.

Level 1 Appeals

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

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

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

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

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

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

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

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

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

Expedited Level 1 Appeals

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

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

Expedited Appeals may be filed by telephone and in writing.

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

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

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

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

Level 2 Appeals and Timeframes

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

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

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

EXTERNAL APPEALS

You may also request an external review by a New York State Department of Insurance appeals agent. You can file an external appeal if benefits were denied:

- For lack of medical necessity
- Because the service was determined to be an experimental and/or investigational procedure
- Because the service to be provided by an out-of-network provider is not materially different than the service available from the plan's network provider. Additional information (e.g. physician certification, medical and scientific documentation, etc.) will be required.

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

To Obtain An External Appeal

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

- The New York State Department of Insurance at 1-800-400-8882 or *www.ins.state.ny.us*
- Empire Member Services at 1-800-453-0113.

Resolving an External Appeal

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

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

Submit your appeal within 45 calendar days:

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

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

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

Standard External Review Process

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

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

Expedited External Appeals

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

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

LEVEL 1 GRIEVANCES

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

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

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

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

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

LEVEL 2 GRIEVANCES

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

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

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

EXPEDITED GRIEVANCES

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

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

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

DECISION ON GRIEVANCES

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

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

HOW TO FILE AN APPEAL OR GRIEVANCE

To submit an appeal or grievance, call Member Services at 1-800-453-0113, or write to the following address with the reason why you believe our decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

The address for filing an appeal or grievance is:

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

If your grievance or appeal concerns behavioral health care, call 1-800-453-0113 or write to:

Empire Behavioral Health Services
370 Bassett Road Bldg. 3, 2nd Floor
North Haven, CT 06473

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 1-800-453-0113.

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 HMO 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 speaks 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.

HIPAA Notice of Privacy Practices

Effective July 1, 2007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Definitions

Refer to these definitions to understand your HMO coverage. Additional terms and definitions can be viewed at *www.empireblue.com***.**

Advance Directives

Any spoken or written decision with your instructions and preferences for medical treatment so that your family and doctor will know who to talk to about your care or kinds of treatment you want or don't want if you are too sick or incompetent to decide.

Ambulatory Surgery

Surgery that does not require an overnight stay in a hospital. Also called same-day or outpatient surgery.

Authorized Services

Covered services coordinated and precertified in writing by the Behavioral Health Care Management Program or by Empire's Medical Management Program.

BlueCard® Program

Empire participates in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard program. The BlueCard program gives you access to care when you are outside of the Local Network Area. By presenting your identification card to any BlueCard participating hospital, physician or other provider outside the Local Network Area anywhere in the United States, you will receive the covered services you would be entitled to receive within the Local Network Area and you will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan subject to certificate limitations that apply to coverage outside Empire's service area.

When you obtain health care services through the BlueCard program, the portion of your claim for covered services that you are responsible for is, in most instances, based on the lower of the following:

- The billed amount that the participating provider actually charges for covered services
- The negotiated price, which may include billed charges reduced to reflect an average expected saving that the local Blue Cross and/or Blue Shield plan passes on to Empire

Here's an example of a negotiated price and how it benefits you:

> A provider's standard charge is $100, but he/she has a negotiated price of $80 with the local Blue Plan. If your coinsurance is 20%, pay $16 (20% of $80) instead of $20 (20% of $100).

The negotiated price may reflect:

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

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

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

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 1-800-453-0113 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.

Certificate of Coverage (Certificate)

Evidence of your health maintenance organization (HMO) coverage and provides detailed information about your benefits.

Clinical Care

The medical treatment you receive.

Clinical Professionals

Doctors, nurses and other licensed health care professionals.

Coordination of Benefits

When a member is covered by two health plans, the benefits from both plans need to be coordinated to prevent duplication of benefits. Requests for coverage should be submitted first to your primary plan. Any portion not covered by the primary plan can then be submitted for payment consideration to your secondary plan. This process is called coordination of benefits (COB). See your Certificate for details on how COB works.

Custodial Care

Helps with daily living activities such as bathing or dressing as defined, by Medicare guidelines. Custodial care does not require trained medical or paramedical staff, nor is it skilled nursing care. Empire does not cover services considered to be primarily custodial. See your Certificate.

Elective Surgery

Surgery that is done on a non-emergency basis.

Exclusion

A service or product that is not covered by your Direct HMO. Your Certificates list the exclusions and limitations that apply to your plan.

Guest Membership

This is a program that provides benefits for covered services when you are temporarily outside of the Local Network Area for business, vacation or school for more than 90 days.

Home Health Care

Skilled nursing care and related services performed in the patient's home by a home health agency.

Hospice

A program that provides medical and supportive care (including pain relief) for terminally ill patients (life expectancy of six months or less). Hospice care includes bereavement counseling for the patients' family.

Hospital/Facility

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

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

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

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

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

For behavioral health care purposes, the definition of "hospital" may include a facility that has an operating certificate issued by the Commissioner of Mental Health under Article 31 of the New York Mental Hygiene Law; a facility operated by the Office of Mental Health; 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, or a facility that has a participation agreement with Empire to provide mental and behavioral health care services. For alcohol and/or substance abuse received out-of-network, a facility in New York State must be certified by the Office of Alcoholism and Substance Abuse Services. A facility outside of New York State must be approved by the Joint Commission on the Accreditation of Health Care 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 on previous page); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps, residential treatment centers.

In-Network Provider

A doctor, other professional provider, or durable medical equipment, home health care or home infusion supplier who is in the HMO Network.

Inpatient

A member who is admitted to a network hospital/facility and fills a bed.

Limitation

A provision of the plan that states Empire covers specific services only under certain circumstance or for a designated number of times, days or visits within a given period. Your Certificate lists the limitations and exclusions that apply to your plan.

Local Network Area

The Local Network Area is the geographic area serviced by the HMO Network. It consists of the following counties:

In New York state: Albany, Broome, Bronx, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Otsego, Washington, Westchester.

In Connecticut:, Fairfield, Hartford, Litchfield, Middlesex, New London, New Haven, Tolland, and Windham

In Massachusetts: Berkshire, Hampden, and Worcester

In Rhode Island: Providence, Kent, and Washington

In Vermont: Grand Isle, Bennington, Rutland, Addison and Chittenden

In Pennsylvania: Pike and Wayne

In New Jersey: Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex, and Union

Medical Necessity

Empire regards services, supplies or equipment provided by a hospital or other provider of health services as medically necessary if Empire determines they 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 In-Network Provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

Member

A person, including eligible covered dependents, enrolled in the Direct HMO.

Out-of-Network Provider

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

Outpatient

Services a patient may receive in a hospital or facility, but not as an admitted patient who fills a bed.

Outpatient Surgery

See Ambulatory Surgery.

Participating Provider

See In-Network Provider.

Retrospective Review for Medical Necessity

A review done after services are completed (usually as part of a claim or appeal), that ensures that the care was medically necessary.

Short Term

Refers to treatment or care intended to improve or restore a member's functioning within a reasonable time. Short-term care is expected to produce a positive result, not maintain functioning or prevent decline.

Skilled Nursing Facility

Provides inpatient medical care, nursing care and rehabilitative services for recovering patients who do not require hospital care, but require medical service.

Specialized Services

Services provided by specialists, not by your PCP. For example, an allergist (who treats allergies) or a radiologist (who uses X-rays for diagnosis and treatment).

Specialty Care Center

A facility accredited or designated by a State agency or voluntary health organization that has special expertise in treating a certain life-threatening or degenerating and disabling condition or disease.