



Welcome to Empire BlueCross BlueShield.

By choosing Empire's HMO, you're linked to quality health care and customer service and thousands of the finest doctors and hospitals through our extensive HMO network. You'll enjoy maximum savings since there are **minimal out-of-pocket costs**.

Enclosed you will find your:

- **MEMBER HANDBOOK** – a guide for accessing health care services covered by your HMO
- **SCHEDULE OF BENEFITS** – detailing your co-payment responsibilities and dependent coverage terms
- **CERTIFICATE OF COVERAGE AND RIDERS** – describing all available benefits and terms and conditions relating to your coverage

Empire is working to help keep you and your family healthy. You will receive a customized package of health information, which can help you to make more informed choices about your health.

If you have questions about your HMO coverage, other available products and programs or would like an online directory of network health care providers, please visit www.empireblue.com. You can also call us at the toll-free number for Member Services that is listed in your handbook.

Again, welcome to Empire's HMO. We look forward to serving you. And thank you for choosing Empire!

HMO

TAKE ADVANTAGE OF THESE EXTRA BENEFITS INCLUDED IN YOUR HEALTH PLAN:

Manage Your Health Care Online!

REGISTER NOW TO DO IT ON THE WEB!

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

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

Plus much more ...

HERE'S WHAT YOU'LL NEED TO DO

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

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

ASSISTANCE IS A CLICK AWAY

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

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

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

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

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

Get health information for you and your family.

YOUR PRIVACY IS PROTECTED

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

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

Future Moms Program

IF YOU ARE HAVING A BABY

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

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

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

360° Health® – Empire’s Health Services Programs

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

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

Empire’s 360° Health is organized into:

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

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

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

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

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

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

- Is having a heart attack or stroke
- Is severely injured
- Is unable to breathe
- May have ingested poisonous or toxic substances
- Is unconscious
- Is experiencing any other symptom that you think constitutes an emergency

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

Here’s how to use 24/7 NurseLine:

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

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

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

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

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

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

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

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

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

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

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

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

AudioHealth Library Topics

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

Abdominal Problems

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

Allergies

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

Back and Neck Pain

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

Bone, Muscle and Joint Problems

1030 Arthritis
1780 Bunions
2103 Bursitis and Tendon Injury
1781 Calluses and Corns
2104 Carpal Tunnel Syndrome
1038 Fibromyalgia
1039 Gout
1784 Heel Spurs
1031 Juvenile Rheumatoid Arthritis
1033 Lupus

2106 Muscle Cramps and Leg Pain
2259 Osteoarthritis
1032 Osteoporosis
1034 Rheumatoid Arthritis
2169 Rotator Cuff
1456 Sports Injuries
2105 Strains, Sprains,
Fractures and Dislocations
2151 Surgery for Carpal Tunnel
Syndrome
1461 TM Disorder

Cancer

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

Chest, Respiratory and Circulatory Problems

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

Chronic Conditions

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

Ear, Nose and Throat

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

Eye Problems

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

First Aid and Emergencies

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

Headaches and Nervous System Problems

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

Home Health Medicines and Supplies

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

Infant and Child Health

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

Infant and Child Health

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

Infectious Diseases

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

Living Healthy

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

Medical Tests and Procedures

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

Men's Health

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

Mental Health Problems and Mind-Body Wellness

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

Partnership with your doctor

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

Senior Health

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

Skin Problems

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

- 2352 Sunburn
- 2353 Warts

Sleeping Disorders

- 2400 Sleep Problems
- 2403 Sleep Apnea
- 2406 Snoring

Women's Health

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

Women's Health

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

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

Welcome!

Your Empire HMO – A Smart Way to Get Health Care

Your HMO, or Health Maintenance Organization, is a network of health care providers available to you from Empire. Our “HMO Network” consists of health care providers who have entered into contracts with us to provide services to Empire’s members.

As a member, you choose a primary care physician (PCP) from the 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 HMO Advantage?

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

- A comprehensive website, www.empireblue.com, for fast, personalized service in a confidential and secure environment.
- Among a large network of doctors and hospitals in New York State.
- Providers that are reviewed for Empire’s high standards of quality.
- A PCP to coordinate your care.
- Easy to use – usually no claim forms to file when you use the In-Network Providers
- Coverage for you and your family members when traveling or temporarily living outside of Empire’s service area*

* Empire’s Service Area consists of the following 28 eastern New York State counties: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

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 HMO ID card
- This Handbook, which gives you information about:
 - Finding fast help online
 - Important telephone numbers and addresses
 - How to use your HMO
 - Plan Features
 - How to file a complaint, grievance, or appeal
- 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

This benefit 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.

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

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

IF YOU ARE LOOKING FOR	YOU'LL FIND IT IN	ON PAGE
• HOW THE PLAN WORKS	USING YOUR HMO	8
• HIGHLIGHTS OF WHAT'S COVERED	FEATURES AND BENEFITS	15
• PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	20
• HOW TO FILE AN APPEAL	DETAILS	36
• DEFINITIONS, COVERED SERVICES, LIMITATIONS AND OTHER PLAN REQUIREMENTS AND DETAILS	CERTIFICATE, RIDERS AND SCHEDULE OF BENEFITS	NEXT SECTION

Our Role in Notifying You

There may be times when benefits and/or procedures may change. We will notify you of any 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 online at www.empireblue.com.

Your HMO Handbook

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Introduction

Getting Answers Your Way

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

On the Internet

Do you have customer service inquiries and need an instant response? Visit 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.

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

By Telephone

WHAT	WHY	WHERE
MEMBER SERVICES	<ul style="list-style-type: none"> 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: 1-800-241-6895 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Get network benefits while you are traveling or temporarily residing outside Empire's Service Area 	1-800-453-0113
BLUECARD® PROGRAM	<ul style="list-style-type: none"> When you need urgent or emergency care outside of Empire's Service Area 	1-800-810-BLUE (2583)
BLUECARD® WORLDWIDE PROGRAM	<ul style="list-style-type: none"> Get benefits while you are away from home through an international network of health care providers 	1-804-673-1177 24 hours a day, 7 days a week.
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Precertification of hospital admissions and certain treatments and procedures. 	1-800-441-2411 8:30 A.M. TO 5:00 P.M., MONDAY-FRIDAY
BEHAVIORAL HEALTH CARE MANAGEMENT	<ul style="list-style-type: none"> 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
FUTURE MOMS PROGRAM	<ul style="list-style-type: none"> 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'S PHARMACY PROGRAM	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • To find a participating vision care provider in your area 	1-800-453-0113 8:00 A.M. TO 8:00 P.M. MONDAY-FRIDAY 9:00 A.M. TO 4:00 P.M. SATURDAY
DENTAL CARE	<ul style="list-style-type: none"> • For questions about your benefits and claims 	1-800-722-8879 8:30 A.M. TO 5:00 P.M. MONDAY-FRIDAY
FRAUD HOTLINE	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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
HMO Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

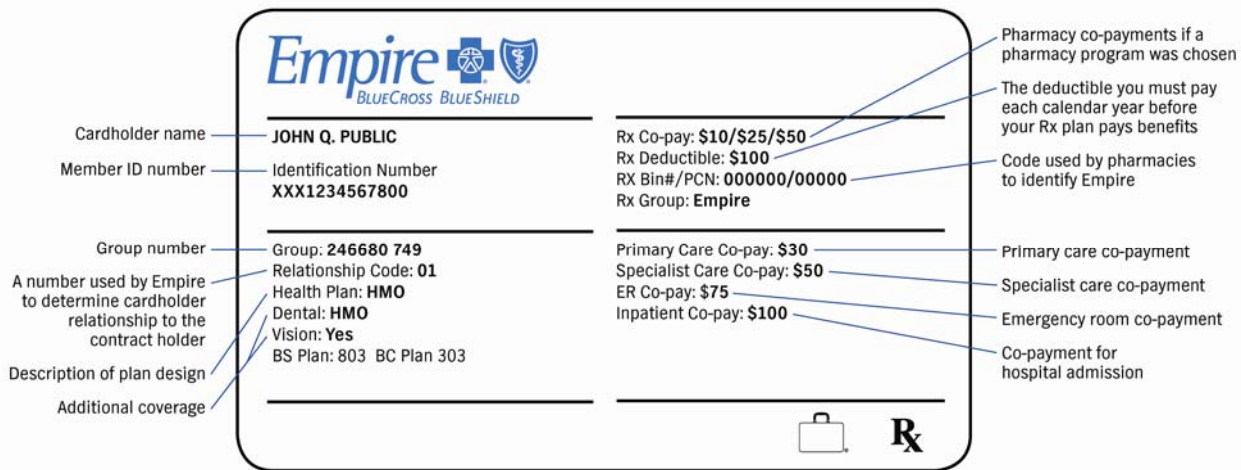
(For dental inquiries, use the address in the "Dental Care" section of this handbook.)

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 determine which coverage you have, look at your actual member ID card.



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 ID 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 yours or your spouse'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've lost my ID card. How can I get a replacement?

A: Visit www.empireblue.com or call Member Services at 1-800-453-0113. By visiting us online, you can 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.

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 HMO

Your PCP

The Empire 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 checkups and screening tests
- Help you select a network specialist
- Maintain your medical history
- Arrange hospital admissions and other special services
- Coordinate precertification of services with Empire's Medical Management Program when required

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 HMO, you may choose from some of the finest physicians in our service area, which covers the 28 eastern counties in New York State. You can check www.empireblue.com or your Provider Directory for a listing of network providers. Our website allows you to search for a provider by name, address, language(s) spoken, specialty and hospital affiliation. The search results also 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 our online 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? 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.

If your plan has both PRIM and SPEC co-payments and you change your PCP, you must confirm that Empire has recorded the change before your office visit with this new doctor, or you must pay the higher SPEC co-payment.

Provider Quality

Whichever network PCP or specialist you choose from the HMO Network, you can be assured that they meet quality standards established by Empire. 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 — within two hours
 - Initial newborn care — within two weeks
 - Routine follow-up care — within two weeks
- See patients promptly when they have an 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 associations (IPAs).

Learn More About Empire Network Doctors

You can get information on the professional qualifications of our network providers by calling Member Services at 1-800-453-0113, 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 at least 30 calendar days prior to the physician's termination or within 15 days after we become aware of the provider's change in status.

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

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 get a referral to specialist or other In-Network Providers for the most covered services. When you do, you will pay a small co-payment otherwise you will pay the full cost for the services you receive. An exception is emergency care – when you need emergency care you do not need a referral.

Precertified/Authorized Services

To help you manage your health, Empire provides Empire's Medical Management Program, a service that precertifies hospital admissions and certain treatments and procedures. This ensures that you receive the highest quality of care for the right length of time, in the right setting and with maximum coverage. Your PCP, specialist or hospital will call Medical Management for precertification of certain services such as planned inpatient surgery, and magnetic resonance imaging and magnetic resonance angiography scans (MRIs and MRAs). However, for the Behavioral Health Care Program, *you* need to call for preapproval and referral for care.

Referrals: Your Best Route to Quality Care

Your PCP is your general medical doctor, but will refer you to specialists in the HMO network when needed. A referral is your PCP's authorization for you to get an advanced level of specialty care. Referrals ensure that the care you get is necessary and appropriate for your condition. They also ensure that your PCP will be informed of your course of treatment and medications to provide any follow-up care. For most covered services, you must get a written referral or benefits will not be paid.

Use this chart as a guide. Refer to your Certificate for a complete list.

IF YOU ARE LOOKING FOR...	PCP REFERRALS NOT REQUIRED FOR...
SPECIALIST APPOINTMENTS	ROUTINE OB/GYNECOLOGICAL SERVICES
LAB TESTS, X-RAYS, MRIs/MRAs AND OTHER DIAGNOSTIC PROCEDURES	MATERNITY CARE
DURABLE MEDICAL EQUIPMENT	PRESCRIPTION DRUGS
AMBULATORY SURGERY	BEHAVIORAL HEALTH CARE
SECOND SURGICAL OPINION	EMERGENCY CARE (Notify PCP within 48 hours of hospital admission)

How Do I Get a Referral?

Your PCP will decide if a specialist is needed. He or she will recommend one and handle the referral for you. Be sure to get the referral in writing. You may then contact the specialist to set up your appointment.

Empire may refer you to an Out-of-Network Provider if there is no network specialist with the appropriate training or expertise for your medical condition. In this situation, your PCP will contact Empire’s Medical Management Program for authorization to refer you to an Out-of-Network specialist. You will receive full network benefits.

The initial referral to a specialist covers in-office procedures, laboratory tests, and most medically necessary X-ray and diagnostic procedures such as Computerized Axial Tomography (CAT) scans. Tests must be performed at a network facility.

How Long Can I Use the Referral?

You have 90 days to use the referral from your PCP. Your PCP can extend this period by indicating this on the referral form. You may also arrange a longer, or “standing” referral if you need ongoing care from your specialist for a specific number of visits or a specific period of time. This standing referral will be provided in writing by your PCP. All standing referrals must be:

- Approved by Empire
- Part of a treatment plan, and
- To a network specialist. However, you may use a non-network specialist if an appropriate network specialist is not available and if the referral is approved in advance by Empire’s Medical Management Program.
 - The specialist may admit you to a network hospital or perform surgery, but Empire’s Medical Management Program must precertify the surgery and hospital admission.
 - If the specialist wants to refer you to another specialist, your PCP must provide the referral.
 - You can ask your PCP to refer you to a network physician in the appropriate specialty for a second or even a third opinion for surgery. No co-payment is required. The physician giving the second or third opinion may not perform the surgery.

When you need specialized care, keep in mind:

- The PCP is not required to refer you to a specialist if your PCP is able to perform the service that you need.
- Referrals must be to the network specialist, unless there is no network specialist with the training or expertise to treat your medical condition.
- The PCP must provide a written referral.
- You need a new referral from your PCP if you need to go back to the specialist, unless you have a referral for multiple visits.
- Your PCP may approve several visits at one time. You can use the referral only for the specified number of visits. You need to complete the visits within 90 days, unless your PCP indicates otherwise on the referral form or, unless you have a standing referral.

The Advantages of Specialty Care Coordinators and Specialty Care Centers

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

- Remind your PCP that you are an HMO member.
- Be sure your PCP provides a written referral. Without a referral from your PCP, the plan will not cover the cost of your care from the specialist, whether in-network or non-network except as described earlier.
- Arrange to have copies of pertinent medical records and test results sent to the specialist in advance or bring them with you.
- Think about what you want to say before you see the specialist. Write down the history of your condition in date order to help the doctor evaluate your present condition.
- Talk to the specialist about treatment options. Go over the benefits and risks associated with each option.

Changing Your Specialist Provider

Usually, when you need services from a specialist provider, your PCP will provide you with an in-network referral to a participating provider that he or she normally refers to in his or her practice. If you want a different specialist provider or you want to change a specialist provider, you should discuss this request with your PCP. He or she will make the appropriate changes to your referral for the new specialist provider. You do not need to call us directly for permission to change participating specialists.

Out-of-Network Referrals

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

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

Services Not Requiring a Referral

Some services do not require referral from your PCP:

- **Routine Obstetrical/Gynecological Services**

You do not need a referral to see a network obstetrician/gynecologist for

- All maternity care. Your doctor must precertify maternity care as soon as reasonably possible; we request notification within the first three months of your pregnancy when possible.
- Routine obstetrical/gynecological pelvic exams including Pap smears.
- Follow-up examinations for the treatment of acute gynecological conditions.

- **Prescription Drugs**

You may order drugs from a network pharmacy or the mail-service program.

- **Behavioral Health Care**

You do not need a referral from your PCP for behavioral health care, but we recommend that you keep your PCP informed of your treatment plans. However, you must contact the Behavioral Health Care Management Program for preapproval before you can receive mental health or alcohol/substance abuse service.

- **Emergency Care**

- The plan covers the treatment of an emergency in a hospital's emergency or urgent care facility. Your PCP provides follow-up care. See the "Emergency and Urgent Care" section.
- The co-payment is waived if you are admitted to the hospital within 24 hours.

Your Empire HMO Benefits Out-Of-Area

When you need health care services outside of Empire's service area, you are eligible for the Guest Membership and BlueCard® Programs.

Guest Membership

When you are outside of Empire's service 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 Empire's Pharmacy Program, 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 "Emergency and Urgent Care" 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 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 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 some of the benefits and features of your Empire 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.

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

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.

Emergency and Urgent Care

If You Need Emergency Care

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

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

Emergency Services are defined as a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

Emergency Services are not subject to prior authorization requirements.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room or urgent care center. If possible, go to the emergency room of a hospital where your PCP is affiliated or one that is in the 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 needs 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.

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 Empire's service area. By presenting your identification card to any BlueCard participating hospital, physician or other provider outside Empire's service area anywhere in the United States, you will receive the covered services you would be entitled to receive within Empire's service 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.

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

In Empire's Service Area:

- If you visit an emergency or urgent care facility, you or your representative should call your PCP within 48 hours of seeking care or as soon as reasonably possible. Your PCP or other network physician must provide all follow-up care.

Outside Empire's Service area:

- If you are going to be outside Empire's service area, and know that you will 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.

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 Dental 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 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 one of Empire’s dental networks and you are comfortable with the care you are receiving, you may nominate him/her 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/she 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 dental 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.

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

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

How Empire's Medical Management Program Helps You

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

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

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

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

CALL TO PRECERTIFY THE REQUIRED SERVICES ...

FOR ALL HOSPITAL ADMISSIONS

- At least two weeks prior to any planned surgery or hospital admission
- Within 48 hours of an emergency hospital admission, or as soon as reasonably possible
- Of newborns for illness or injury
- Before you are admitted to a rehabilitation facility or a skilled nursing facility

MATERNITY CARE

- As soon as reasonably possible; we request notification within the first three months of pregnancy when possible
- Within 48 hours after the actual delivery date, if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth.

BEFORE YOU RECEIVE/USE

- For Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification
- Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs
- Outpatient treatment for Mental Health Care and Substance Abuse Care
- Occupational, physical and speech therapy
- Outpatient/ Ambulatory Surgical Treatments (certain procedures)
- High tech radiology services: MRI, MRA, PET, CAT, CTA, MRS, CT/PET, SPECT, ECHO Cardiology, Nuclear Technology services
- Diagnostics
- Outpatient Treatments
- Durable medical equipment, prosthetics, orthotics
- Occupational, Vision and Speech Therapy
- Chiropractic care*
- Air ambulance

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

If Services Are Not Precertified

Failure to comply with the Medical Management Program requirements set forth in your Benefit Contract will result in penalties or denial of benefits. Please refer to "RIDER TO YOUR CONTRACT OR CERTIFICATE REGARDING PRECERTIFICATION AND PRIOR AUTHORIZATION REQUIREMENTS" of the Benefit Contract for more information.

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 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 the 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 the denial of coverage decision.
- **Urgent Precertification Requests.** If the need for the service is urgent, we will render a decision as soon as possible, taking into account the medical circumstances, but in any event within 72 hours of our receipt of the request. If the request is urgent and we require further information to make our decision, we will notify you within 24 hours of receipt of the request and you and your provider will have 48 hours to respond. We will make a decision within 48 hours of our receipt of the requested information, or if no response is received, within 48 hours after the deadline for a response.
- **Concurrent Requests.** Concurrent review means that Empire reviews your ongoing care during your treatment or hospital stay to be sure you get the right care in the right setting and for the right length of time. When the request to continue care is received at least 24 hours before the last approved day, we will complete all concurrent reviews of services within 24 hours of our receipt of the request.
- **Retrospective Requests.** Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, a clinical denial of coverage rendered. The letter you receive will tell you how to appeal the denial of coverage decision.

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

If a Request Is Denied

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

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by phone 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.

Details

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.

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 health 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.

Portability of Coverage

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

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

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

As a member of our plan, you can request a Certificate of Creditable Coverage letter at any time by calling Member Services at 1-800-453-0113.

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 HMO makes health care easy by paying In-Network Providers directly for their services. When you use your 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 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 HMO plan is the secondary payor, submit the primary payor's Explanation of Medical Benefits (EOB) with your itemized bill. Do not send a photocopy.
- Keep a copy of your claim form and all attachments for your records.

Want more claim information? Now you can check the status of a claim, request a duplicate EOB, correct certain claim information and much more at anytime of day or night just by visiting www.empireblue.com.

If You Have 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.

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, you may 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
HMO Member Services
PO Box 1407
Church Street Station
New York, NY 10008-1407

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

Notice of Qualifying Events:

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

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

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

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

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

FOR MORE INFORMATION

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

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

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

THE RIGHT TO ELECT ADDITIONAL CONTINUED COVERAGE UNDER NEW YORK STATE LAW WHEN CONTINUED COVERAGE UNDER FEDERAL LAW ENDS

Covered Persons who have exhausted continued coverage available under COBRA may purchase additional continued coverage as permitted by the New York State Insurance Law up to a total of thirty-six (36) months from the date continued coverage under federal COBRA began.

Note: This right to elect additional continued coverage does not apply to Covered Members who elect to continue coverage through age twenty-nine (29) under the New York Young Adult Mandatory Right of Election.

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 services without a referral from your PCP, 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.
- 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.

*Please refer to the riders located in the back of this book, for additional information regarding the External Appeals Process for Experimental/Investigational denials for the treatment of rare diseases.

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

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.

**EMPIRE HEALTHCHOICE HMO, INC.
SCHEDULE OF BENEFITS**

1.	Age Limits	
	Dependent Children	26
	Students	26

COST-SHARING AMOUNTS

2.	Home & Office Visit Copayments	
	a. Primary Care	\$25
	b. Specialist	\$25
	c. Therapies: Physical, Occupational, Speech, Vision	\$25
	d. Alcoholism & Substance Abuse Treatment	\$25
	e. Mental Health Care	\$25
	f. Second Surgical Opinion	\$0
	g. Home Health Care Visits	\$0
3.	Outpatient Services Copayments	
	a. Surgical Procedures performed in the Office	
	Primary Care	\$25
	Specialist	\$25
	b. Medical Supplies	\$25
	c. Diabetic Equipment, Supplies, Education, Insulin, Oral Agents	\$25 (up to 52 combined Copayment Maximum per member per Calendar Year)
	d. Diagnostic Radiology Services	\$25
	e. Laboratory Services	\$0
	f. Hemodialysis	\$0
	g. Chemotherapy and Radiation Therapies	\$0
	h. Ambulatory Surgery Center and Outpatient Procedure Services Copayment	\$75

4.	Other Services Cost-Sharing	
	a. Emergency Room Copayment	\$75
	b. Ambulance Copayment (Land and Air)	\$0
	c. Durable Medical Equipment Coinsurance	20%
	d. Prosthetic and Orthotic Appliances Coinsurance	20%
	e. Treatment of Allergies	\$0
5	Inpatient Admissions Copayment	
	Inpatient Hospital	\$250
	Skilled Nursing Facility	\$0
	Hospice Care (Inpatient)	\$0
	Inpatient Calendar Year Copayment Maximum	\$625

DAY/VISIT MAXIMUMS PER PERSON PER CALENDAR YEAR

6.	Skilled Nursing Facility Care	60
7	Hospice Care Days	210 per lifetime
8.	Home Health Care Visits	200
9	Alcoholism & Substance Abuse Treatment	
	Outpatient Service Visits, any combination – Home, Office, Outpatient Department	Unlimited
	Inpatient Detoxification Days	Unlimited
	Inpatient Rehabilitation Days	Unlimited
10.	Mental Health Care	
	Outpatient Service Visits, any combination – Home, Office, Outpatient Department	Unlimited
	Inpatient Days	Unlimited
11.	Physical Therapy	
	Outpatient Service Visits, any combination – Home, Office, Outpatient Department	30
	Inpatient Days	30
12.	Occupational/Speech/Vision Therapies	
	Outpatient Service Visits, any combination – Home, Office, Outpatient Department	30

**EMPIRE HEALTHCHOICE HMO, INC.
HMO PRESCRIPTION DRUG RIDER
SCHEDULE OF BENEFITS**

1. Annual Deductible * n/a
Per Covered Person, Per Calendar Year

2. Copayments (Retail Pharmacy)

All drugs purchased through retail pharmacy will be subject to one copayment for each supply of up to 30 days, as shown below:

<u>Category of Drug</u>	<u>Up to 30 day supply</u>
Tier 1	\$10
Tier 2	\$25
Tier 3	\$50

3. Copayments (Mail Order)

A supply of drugs for up to 90 days can be purchased through Empire's mail order program, as shown below. You will be required to pay two copayments for each supply between 31 and 90 days. You will be required to pay one copayment for each 30 day or less supply.

<u>Category of Drug</u>	<u>Up to 30 day supply</u>	<u>31 to 90 day supply</u>
Tier 1	\$10	\$20
Tier 2	\$25	\$50
Tier 3	\$50	\$100

* The annual pharmacy deductible is waived for drugs purchased through Empire's mail order program.



This is your
EMPIRE HEALTHCHOICE HMO, INC.
CERTIFICATE OF COVERAGE

Issued by
EMPIRE HEALTHCHOICE HMO, INC.

This is your Certificate of health maintenance organization coverage provided by Empire HealthChoice HMO, Inc.

IMPORTANT NOTICE

In order to receive benefits under this Certificate you must contact your Primary Care Physician (“PCP”) in advance, except in an emergency as described in Section Seven of this Certificate. Empire HealthChoice HMO, Inc. will only pay for medically necessary care provided by Participating Providers as authorized by your PCP, except in an emergency or unless specifically stated otherwise in this Certificate.

EMPIRE HEALTHCHOICE HMO, INC.
CHURCH STREET STATION P.O. BOX 3509
NEW YORK, NY 10008-3509

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President

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SECTION ONE – INTRODUCTION; DEFINITIONS; MEDICAL MANAGEMENT PROGRAM

- 1. Health Care Through The HMO Concept.** This Certificate provides coverage through a Health Maintenance Organization (HMO). In an HMO all care must be medically necessary and must be provided, or authorized in writing in advance, by your PCP. Except for emergencies, payment for care you receive without the prior written approval of your PCP will be denied, even if it is medically necessary. In addition, benefits will only be provided for care that is rendered by Participating Providers, except in the case of an emergency or when, in our sole judgment, the care you require is not available from a Participating Provider and we preauthorize services of the non-participating provider.

In some cases, your PCP may provide or approve services that are not covered by Empire because they are specifically excluded in this Certificate. In spite of your PCP's authorization, Empire will not pay for these services.

Since care must be provided or authorized by your PCP, coverage is not available, and we will not pay for, any services unless you have a PCP. Each person who has this HMO coverage should select a PCP from the list of Participating HMO Primary Care Physicians. If you do not select a PCP, we will assign one. Throughout this Certificate, the Participating HMO Primary Care Physician you have selected will be referred to as "your PCP."

- 2. Words We Use.** Throughout this Certificate, Empire will be referred to as "we," "us" or "our." The word "you," "your," or "yours" refers to you, the one person to whom this Certificate is issued. If family coverage was selected, then in most cases the word "you" also includes any members of your family who are covered under this Certificate.
- 3. Group Subscriber.** You are covered under this Certificate as a group subscriber because an organization, such as an employer, union or association arranged for your coverage. To be a group subscriber, you must meet our group eligibility rules. Your group then acts on your behalf, sending us the premium for this coverage. The group has a contract with us to provide HMO coverage. Under that contract we will provide the benefits described in this Certificate. This Certificate is not a contract between you and us, but you should keep it with your important papers and refer to it if you have questions about your coverage.
- 4. Definitions.** The following definitions apply to your HMO coverage:

Certificate means this certificate of coverage.

Copayment means the amount of payment you must make for some services. It includes the visit fees you must pay for visits to physicians and, for example, the payment you must make for care in a hospital emergency room when you are not admitted as an inpatient within one day for the same condition.

Custodial Care means care which we determine is designed chiefly to assist a person to meet her or his activities of daily living as defined by Medicare Guidelines. Such care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled nursing care. Examples of custodial care include but are not limited to:

- A. Service which constitutes personal care, such as walking and getting in and out of bed, aid in bathing, dressing, feeding, and using the toilet;
- B. Preparation of special diets; or
- C. Supervision of medication which usually can be self-administered.

Facilities means a hospital, ambulatory surgery facility, birthing center, dialysis center, rehabilitation facility, skilled nursing facility or other provider certified under Article 28 of the N.Y. Public Health Law; a hospice; or an institutional provider of mental health substance abuse treatment operating under Article 31 of the N.Y. Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services.

HMO means Empire HealthChoice HMO, Inc.

Medical Management Program means the managed care program described below in this Section. Compliance with the Medical Management Program is required in order to receive benefits under this Certificate.

Medically Necessary means care which, according to our criteria, and in our judgment, is:

- Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury;
- In accordance with standards of good medical practice;
- Not solely for your convenience, or that of your physician or other provider;
- Not primarily custodial; and
- The most appropriate supply or level of service which can safely be provided to you.

Mental and Behavioral Health Care Manager means the managed care program designed to provide advance, written authorization for mental health care benefits. This includes benefits for alcohol and substance abuse.

Participating Physician means a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has an agreement to provide covered services to HMO members.

Participating Provider means any professional provider, or a hospital, skilled nursing or other Facility, home health agency, laboratory, or any other person or entity which has an agreement to provide covered services to HMO members and participates in the network chosen by your group. We will not pay for health services from a non-participating provider except in an emergency or when, in our sole judgment, the care you require is not available from a Participating Provider and we preauthorize services of the non-participating provider.

Primary Care Physician (“PCP”) means the Participating Physician you select when you enroll in the HMO, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.

Referral Care means covered medical care which is provided by a participating practitioner other than your PCP and which is:

- Authorized, in advance, by your PCP, in writing or by such other method as we may designate from time-to-time; and
- Limited in scope, duration or number of visits to that authorized by your PCP.

Service Area means the 28 counties in eastern New York including New York City and from there north through Clinton County, and east through Suffolk County. Specifically, those counties are: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Skilled Care means a service which we determine is furnished by or under the direct supervision of licensed medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result as defined by Medicare Guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical or paramedical personnel. However, it is a service which cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

5. **Medical Management Program.** The Medical Management Program (MMP) is a program which must be complied with in order to receive the benefits available under this Certificate. MMP works with you and/or your Participating Provider to ensure that you receive medically appropriate health services at an appropriate level of medical care.

The following services require authorization prior to your receiving the services:

A. You or your PCP must call the Mental and Behavioral Health Care Manager for authorization prior to receiving the following services:

- Inpatient or outpatient mental health care;
- Inpatient alcohol and substance abuse detoxification;
- Outpatient alcohol and substance abuse care.

The Mental and Behavioral Health Care Manager can be contacted at the telephone number listed on your identification card.

B. The following services must be preauthorized by MMP:

- All inpatient admissions;
- Air ambulance;
- Ambulatory surgery;
- Cardiac rehabilitation;
- Durable medical equipment and prosthetics;
- Home care and home infusion therapy;
- Hospice care;
- MRIs;
- Occupational and physical therapy;
- Skilled nursing facility care;
- Speech therapy;
- Vision therapy.

C. MMP must be called:

- At least two weeks prior to the planned admission or surgery when your Participating Physician recommends inpatient hospitalization. If that is not possible, then during regular business hours any time prior to admission.
- Within 24 hours after you are admitted to a hospital because of an Emergency or as soon as reasonably possible.
- Within the first three months of a pregnancy and again within 24 hours after the actual delivery date or as soon as reasonably possible.
- In all other cases, prior to receiving the services.

The MMP staff must be contacted by your attending Participating Physician, Home Health Agency, Durable Medical Equipment or Prosthetics Vendor, as appropriate.

The MMP staff will discuss the planned level of care with you and your attending Participating Physician to determine a level of care which is appropriate to the planned health services and advise you, your attending physician, and the hospital in writing and by telephone of the approved level of care within three (3) business days after the staff receives all the necessary medical information from the attending physician.

The preauthorization of benefits by the MMP or the Mental and Behavioral Health Care Manager does not guarantee payment of benefits. All benefits must be Medically Necessary as determined by us. The payment of benefits is limited by the terms, conditions and limitations of this Certificate.

D. Please refer to your HMO Member Handbook for a description of how you or your provider can appeal a decision by MMP.

SECTION TWO – WHO IS COVERED

1. **Who is Covered.** You, the person to whom this Certificate is issued, are covered under this Certificate and, if you selected family coverage, the following members of your family are also covered:
 - A. Your wife or husband, unless you are divorced or your marriage has been annulled.
 - B. Your unmarried children who are under the age limit shown on the attached Schedule of Benefits. Coverage of each child lasts until December 31 of the calendar year in which the child becomes that age, or the date of marriage, whichever occurs first.
 - C. Your unmarried children who are unable to work or support themselves because of mental illness, developmental disability or mental retardation, as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age at which coverage would otherwise terminate according to this Section. The child's disability must be certified by a physician. In addition to this certification, we have the right to check whether a child is and continues to qualify as an incapacitated child.
 - D. Your unmarried children under the age shown on the attached Schedule of Benefits, enrolled as full-time students at an accredited institution of learning. The students' principal residence, when not away at school, must be the same as their parents'. Coverage of each child lasts until December 31 of the calendar year in which the child no longer meets all of these conditions, or the date of marriage, whichever occurs first.
2. **Other Covered Children.** If you have family coverage the following other children, in addition to the natural children of you and your spouse, are also covered if the child meets the above criteria for covered children:
 - A child for whom you are the legal guardian and who is chiefly dependent upon you for support.
 - A child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final. Foster children are not included.
3. **Newborn Child.** If you have family coverage, your newborn child will be covered from the date of birth. However, if a child of yours who is covered gives birth, that newborn grandchild will not be covered. If the grandparent adopts the newborn, coverage will be effective as described in Paragraph 4 below. If the grandparent becomes the legal guardian of the child, the child will be covered from the effective date of the legal guardianship.

If you have individual or two-person coverage, any newborn child will be covered for thirty (30) days from the date of birth. If you have individual or two-person coverage at the time your child is born, you must switch to two-person or family coverage to receive further benefits and to obtain coverage for your newborn from the moment of birth. You must notify us of your desire to switch to two-person or family coverage and we must receive the applicable premium for the new coverage within 60 days of the birth. If you decide to switch to two-person or family coverage but fail to notify us or we do not receive the applicable premium within 60 days of the birth, you must wait until the group's open enrollment period; in that case, the coverage will not become effective until the first day of the month following the date the request is received and the applicable premium is paid.

4. Coverage of Adopted Newborns.

- A. **When We Will Cover Adopted Newborns from the Moment of Birth.** If you have family coverage, or switch to two-person or family coverage in accordance with Paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:
 - You (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth; and
 - You file a petition pursuant to Section 115-c of the New York State Domestic Relations Law within 30

days of the infant's birth.

- B. When We Will Not Cover Adopted Newborns From the Moment of Birth.** Notwithstanding the provisions of Paragraph A. above, we will not cover adopted newborns from the moment of birth if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If we pay benefits to cover an adopted newborn and the notice of the adoption is revoked, or one of the natural parents revokes consent, we shall be entitled to recover any sums paid by us for care of the adopted newborn.
- 5. Persons Not Covered.** If you live outside our Service Area you are not eligible for coverage under this Certificate unless you work in the Service Area and receive all covered health care there.
- 6. When Coverage Begins.** Coverage under this Certificate will begin as follows:
- A. If you elect coverage before becoming eligible for coverage, coverage begins on the date you become eligible, or on the date on which we receive and accept from you a completed application, whichever is later.
 - B. If you do not elect coverage upon becoming eligible, you must wait until the group's open enrollment period. Coverage then begins on the date on which we receive and accept from you a completed application.
 - C. If you marry while covered, and we receive notice of such marriage within thirty (30) days thereafter, coverage for the spouse starts on the date of such marriage; otherwise you must wait until the group's open enrollment period; and in that case the spouse's coverage begins on the date on which we receive and accept from you a completed application.
- 7. When You Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage.** If you reject initial enrollment under this Certificate, you may enroll for coverage if all of the following conditions are met:
- A. You were covered under another plan or contract when coverage was initially offered.
 - B. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or coverage under the other plan or contract was terminated because you lost eligibility for one or more of the following reasons:
 - termination of employment;
 - termination of the other plan or contract;
 - death of the spouse;
 - legal separation, divorce or annulment;
 - reduction in the number of hours worked; or
 - the employer or other group ceased its contribution toward the premium for the other plan or contract.
 - C. You apply for coverage under this Certificate within 30 days after termination for one of the reasons set forth in Paragraph B. above.

SECTION THREE – HOSPITAL CARE

- 1. Inpatient Care in a Hospital.** We will pay for the following services if they are customarily furnished by a hospital when you are a registered bed patient in a hospital:
- bed and board, including special diet and nutritional therapy
 - general, special, and critical care nursing service, but not private duty nursing services
 - facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care

- oxygen and other inhalation therapeutic services and supplies
- drugs and medications which are listed and approved for such use in the most recent Physician's Desk Reference, American Medical Association Drug Evaluations, American Hospital Formulary Drug Service Information, the United States Pharmacopeia Drug Information or other similar authoritative source
- sera, biological, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies
- blood, blood products, and blood derivatives and services and equipment related to their administration
- facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including, but not limited to, laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations
- social, psychological and pastoral services
- facilities, services, supplies and equipment related to radiation and nuclear therapy
- facilities, services, supplies and equipment related to Emergency medical care
- any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital except to the extent that they are excluded by this Certificate
- chemotherapy
- radiation therapy.

We will only pay for these services if all the following conditions are met:

- A. Except in an Emergency, as defined in Section One above, the hospital is a "participating hospital." A participating hospital is a hospital which has an agreement with us to participate as an HMO network hospital.
- B. Except in an Emergency, your admission is authorized in advance by your PCP following certification by MMP.
- C. While in the hospital you remain under the care of your PCP or another physician designated by your PCP.
- D. The service is given to you by an employee of the hospital, the hospital regularly bills for the service and the hospital retains the money collected for the service.

You do not have to meet all of the conditions described above for an admission to a hospital in an Emergency. See Section Seven.

Maternity Benefits. Inpatient hospital benefits include coverage for a mother and for her newborn for at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section, and for at least ninety-six (96) hours following a cesarean section.

If the mother decides to be discharged earlier than forty-eight (48) hours after childbirth for any delivery other than a cesarean section or ninety-six (96) hours following a cesarean section she shall be entitled, upon request made within that time period, to one home care visit. The visit shall be delivered within twenty-four (24) hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits described in Section Four. The home care visit shall not be subject to any copayment.

Inpatient Mastectomy Stays. Our coverage of inpatient hospital care includes coverage of any inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of the stay will be determined by you and your doctor.

Copayment for Inpatient Hospital Care. You must pay the copayment amount shown on the attached Schedule of Benefits when you are: admitted as an inpatient to a hospital as described in Paragraph 1 above.

The copayment applies to: psychiatric care; treatment of alcoholism and substance abuse; and inpatient admissions for physical therapy, physical medicine or rehabilitation. You do not have to pay the copayment for inpatient skilled nursing facility care described in Paragraph 5.C. below. You do not have to pay the copayment more than once in a single inpatient confinement. A single confinement includes a readmission within

90 days.

If you selected family coverage, after the total of copayments made by you and your family reaches the amount shown on the Schedule of Benefits, no one in your family will have to make any copayments for the remainder of that year.

- 2. Outpatient Care in a Hospital.** Subject to the limitations described below, we will also pay for the same services provided to you in the outpatient department of a Participating Hospital as we would pay for if you were an inpatient. As in the case of inpatient care, your visit to the outpatient department must be authorized in advance by your PCP. Ambulatory surgery must also be pre-certified by us. Outpatient treatment of mental and nervous conditions is subject to the limitations set forth in Section Six below.

Ambulatory Surgery. We will pay for the participating Facility charges for covered surgery or procedures your physician recommends be performed in an ambulatory surgery setting.

Ambulatory surgery is defined as surgery consisting of surgical or invasive diagnostic procedures performed on patients who have not been admitted to hospitals as inpatients. Such procedures require the utilization of a surgical operating room and postoperative recovery room, may require the administration of local or general anesthesia, and must be limited to patients for whom admission as hospital inpatients is not otherwise Medically Necessary and appropriate. Ambulatory surgery procedures are limited to those procedures which could appropriately justify admission to a hospital for inpatient services in the absence of an ambulatory surgery program.

Outpatient Surgery. We will also pay for the participating Facility charges for surgery which includes closed reduction of fractures, dislocations of bones and endoscopies requiring the use of the surgical Facilities, and are normally provided in a doctor's office, such as the removal of cysts, warts, splinters or sutures. It does not include inoculation, vaccination, collection of blood, drug administration or injection.

Therapy Services. We will only pay for up to 30 visits per member per year for physical therapy and 30 visits per member per year for occupational and/or speech and/or vision therapy under the following conditions:

- The therapy must be skilled therapy. Skilled therapy is therapy which must be furnished by skilled licensed medical personnel in order to assure your safety and achieve the medically desired result.
- The therapy must be short term and intended to improve or restore your bodily functions within a reasonable and generally predictable period of time (usually not more than 60 days). We will not pay for maintenance therapy or therapy designed only to prevent further deterioration.
- We must certify the services in advance.

The 30/30 visit limits include, and are not in addition to, therapy services provided under Section Four.

Mammography Screening. We will pay for mammography screening for occult breast cancer as follows:

- Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer;
- A single baseline mammogram if you are age 35 through age 39 inclusive;
- A mammogram every 2 years, or more frequently upon the recommendation of a physician, if you are age 40 through 49 inclusive; and
- An annual mammogram if you are age 50 and older.

"Mammography Screening" shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

Cervical Cancer Screening. We will pay for cervical screening for females in the outpatient department of a participating hospital. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

Blood. We will pay for blood or human blood derivatives during an emergency or ambulatory surgery. We will also pay for this service outside of the hospital.

Pre-Surgical Testing. We will pay for pre-surgical testing when performed at the Participating Hospital where the surgery is scheduled to take place, if:

- reservations for a hospital bed and for an operating room at that hospital have been made prior to performance of the tests;
- your physician has ordered the tests; and
- proper diagnosis and treatment require the test; and
- the surgery takes place within 7 days of the tests.

If surgery is canceled because of these pre-surgical test findings or as a result of a Second Surgical Opinion we will still cover the cost of these tests, but they will not be covered when surgery is canceled for any other reason. See Section Four, Paragraph 3.I. for information concerning benefits for a Second Surgical Opinion.

3. Hospital Services Not Covered. We will not provide the following services:

- A. Private duty nurses.
- B. Private room. If you occupy a private room, you will have to pay the difference between the hospital's charges for a private room and the hospital's most common charge for semi-private accommodations.
- C. Non-medical items, such as television rental and telephone charges.
- D. Medications, supplies and equipment which you take home from the hospital or other facility.

4. Number of Days of Hospital or Other Facility Care. We will pay for care in a Participating Hospital under the conditions described above, on any day we determine that hospitalization was Medically Necessary for the care or treatment of your condition, illness or injury. We will not provide care after a date we determine that hospitalization was no longer Medically Necessary unless requested to by an external appeal agent. There are limitations on the number of days of care for psychiatric care, alcoholism or substance abuse, or nursing home care, which are described in "5" below.

5. Limitations on Inpatient Care. Inpatient care will be limited in the following cases:

- A. **Psychiatric Care; Treatment of Alcoholism and Substance Abuse.** Inpatient admissions for psychiatric care and/or treatment of alcoholism or substance abuse are subject to the limitations set forth in Section Six below.
- B. **Physical Therapy, Physical Medicine or Rehabilitation.** We will pay for 30 days in a calendar year for inpatient admissions to a Participating Hospital exclusively for physical therapy, physical medicine or rehabilitation or a combination of these services. We will only pay for services provided according to a plan of care in which you actively participate. The care you receive must be short term and reasonably expected to improve or restore your bodily functions within a reasonable and generally predictable period of time. We will not pay for care to maintain you at your present level or to prevent further deterioration.
- C. **Care in a Skilled Nursing Facility.** We will provide care in a participating skilled nursing facility if we determine that hospitalization would otherwise be medically necessary for all or part of the care of your condition, illness or injury and MMP pre-certifies your admission.

Your Participating Physician must refer you to the skilled nursing facility prior to the time you entered the Facility and submit a written treatment plan to MMP which certifies: your condition, the projected length of stay in the Facility, the skilled services you are to receive in the Facility, and the intended benefits of this care in the Facility.

We must determine that you needed and actually received skilled nursing care or skilled rehabilitation service on a daily basis. A skilled service is one which must be furnished by skilled licensed personnel to assure your safety and achieve the medically desired result.

We will not pay for more than the number of days of care per person, per year shown on the attached Schedule of Benefits. We will not pay for custodial care as defined in Section One above.

SECTION FOUR – MEDICAL SERVICES

1. **Medical Services Generally.** Under this Section, we will provide coverage for the medical services listed. For purposes of Paragraphs 2-4 below in this Section, Medical Services means care provided by your PCP and the PCP's staff, care provided by the following other Participating Providers when authorized in advance by your PCP: physician, osteopath, optometrist, podiatrist, chiropractor, physical therapist, certified nurse-midwife practicing under qualified medical direction in conjunction with a facility licensed under Article 28 of the Public Health Law of New York State, speech-language pathologist or audiologist, or licensed independent laboratory. We will also pay for services of non-participating medical professionals to whom your PCP refers you when the PCP has first obtained our approval to do so.
2. **Medical Services While Hospitalized.** During any period of hospitalization for which we provide care under Section Three, you will be entitled to the service of a Participating Physician and other Participating personnel, including surgical services, if the service is performed, or prescribed or authorized in advance, by your PCP. However, if two or more surgical procedures are performed through the same incision, we will only pay for the procedure with the highest fee schedule amount. If two or more procedures are performed through different incisions at the same operation, we will pay for the procedure with the highest fee schedule amount and 50% of the fee schedule amount for the other procedures.

Breast Reconstruction Surgery. Coverage of surgical services includes: all stages of reconstructive surgery on a breast on which a mastectomy has been performed; reconstructive surgical procedures on the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. This coverage will be provided in a manner determined in consultation with the Attending Physician and you.

3. **Office Visits.** You are entitled to the following medical services:
 - A. **Preventive Health Services.** All necessary health education and counseling services. Also included are: physical examinations; well child care; clinical laboratory and radiological screening tests such as screenings for colorectal cancer, hypercholesterolemia, diabetes mellitus for women who are pregnant or contemplating pregnancy, when the screenings are provided according to nationally recognized criteria; and immunizations.
 - B. **Diagnosis and Treatment.** Services of PCPs and other Participating medical personnel for diagnosis and treatment of disease, injury, or other conditions. This includes surgical procedures and consultations with specialists. Coverage is also available for up to 30 visits per member per year for physical therapy and 30 visits per member per year for occupational and/or speech and/or vision therapy and is subject to the following conditions:
 - The therapy must be skilled therapy. Skilled therapy is therapy which must be furnished by skilled licensed medical personnel in order to assure your safety and achieve the medically desired result.
 - The therapy must be short term and reasonably expected to improve or restore your bodily functions within a reasonable and generally predictable period of time (usually not more than 60 days). We will not pay for maintenance therapy or therapy designed only to prevent further deterioration.
 - We must certify the services in advance.

The 30/30 visit limits include, and are not in addition to, therapy services under Section Three, Paragraph 2 above.

C. **X-Ray and Laboratory Services.** X-ray and laboratory tests and services. This includes prescribed diagnostic x-rays, x-ray therapy; fluoroscopy; electrocardiograms; laboratory tests; and diagnostic clinical isotope services.

D. **Mammography Screening.** We will pay for mammography screening for occult breast cancer as follows:

- Upon the recommendation of a physician, a mammogram at any age if you have a prior history of breast cancer;
- A single baseline mammogram if you are age 35 through age 39 inclusive;
- A mammogram every 2 years, or more frequently upon the recommendation of a physician, if you are age 40 through 49 inclusive; and
- An annual mammogram if you are age 50 and older.

“Mammography Screening” shall mean an x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

E. **Radiation Therapy and Chemotherapy.** We will pay for radiation therapy and chemotherapy.

F. **Medications for Use in the Office.** Medications, injectables excluding self- injectables, radioactive materials, dressings and casts, used by your PCP or other Participating Provider in the physician’s or provider’s office for preventive or therapeutic purposes.

G. **Obstetrical and Gynecological Services.** The full range of obstetrical services, including prenatal visits and postnatal visits, and all of the other services set forth above, will be provided with respect to pregnancy. However, we will not pay for any services in connection with artificial insemination or assisted reproductive technology unless otherwise required by law. If you join the HMO after the first trimester of pregnancy, you may continue services from a non-participating physician. You do not need your PCP’s authorization when care is provided by a qualified Participating Provider of obstetric and/or gynecologic services. You may also receive the following services from a qualified Participating Provider without your PCP’s authorization:

- Up to two (2) annual examinations for primary and preventive obstetric and gynecologic care; and
- Obstetric and gynecologic care required as a result of such annual examinations or as a result of an acute gynecologic condition. The Participating Provider must discuss the services and treatment plan with your PCP according to the HMO’s requirements.

H. **Allergy Testing and Treatment.** All tests to determine the nature of allergies and desensitization treatments to alleviate allergies, including test or treatment materials.

I. **Second Surgical Opinion.** If you request a second opinion, we will provide a second surgical opinion if:

- Your PCP recommends that surgery be performed; and
- The second surgical opinion is rendered by a Participating Physician who is a board certified specialist and who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed; and
- The second surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Certificate if such surgery were performed; and
- The specialist who renders the second opinion does not also perform the surgery for which the second opinion was obtained.

J. **Diabetes Equipment, Supplies and Education.** We will pay for the following equipment and supplies provided by Participating Providers when recommended or prescribed for the treatment of diabetes by a Participating Physician or other Participating Provider authorized by law to prescribe (“Authorized Participating Providers”):

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Test strips for glucose monitors; and visual reading and urine testing strips;
- Data management systems;
- Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices;
- Oral agents for controlling blood sugar; and
- Additional medically necessary equipment and supplies, as may be required by the New York State Department of Health.

We will also pay for diabetes self-management education and diet information provided by Participating Physicians or Authorized Participating Providers, or their staffs, in connection with medically necessary visits, upon the diagnosis of diabetes, a significant change in the patient's symptoms, the onset of a condition necessitating changes in self-management, or where re-education is medically necessary as determined by us. When such education is provided as part of the same office visit as diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. We will also pay for home visits, when medically necessary.

Education is also covered when provided by the following Participating Providers upon referral from a Participating Physician or Authorized Participating Provider: Certified Diabetes Nurse Educator, Certified Nutritionist, Certified Dietician, Registered Dietician or other provider required by law. Such education must be provided in a group setting, when practicable.

- K. **Second Medical Opinions Concerning Cancer Diagnoses.** We will pay for an office visit and related diagnostic tests in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when the member is diagnosed by the member's physician as having some form of cancer. A negative diagnosis of cancer occurs when the member's physician performs a cancer screening exam on the member and finds that the member does not have cancer, based on the exam results. We will also pay for a second medical opinion concerning any recommendation for a course of treatment for cancer. The specialist rendering the second medical opinion will include, but not be limited to, a specialist affiliated with a specialty care center for the treatment of cancer and must be a participating specialist to whom the member received an approved PCP referral, unless the member received an approved PCP referral to a non-participating specialist which shall be at no additional cost to the member.
- L. **Chiropractic Care.** We will provide services in connection with the detection and correction (by manual or mechanical means) of: structural imbalance; or distortion; or subluxation; in the human body for the purpose of removing nerve interference and the effects thereof. This includes cases when the nerve interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

4. Services in Your Home.

- A. **Visits by your PCP.** In unusual circumstances your PCP may provide care in your home if the home visit is Medically Necessary.
- B. **Visits by Participating Home Health Agency Personnel.** We will provide up to 200 visits per calendar year for visits by participating Home Health Agency personnel in your home if we determine that the visit is Medically Necessary and pre-certify the visit(s). The visit may include the following care:
- Part-time or intermittent skilled home nursing care by or under the supervision of a registered nurse. We do not cover full-time or 24 hour per day nursing.
 - Part-time or intermittent home health aide services which consist primarily of caring for you.
 - Physical, occupational or speech therapy if provided by participating Home Health Agency personnel approved by your PCP.
 - Medical supplies, drugs and medications furnished in connection with a visit by medical professionals or participating Home Health Agency personnel.

Part-time or intermittent means at scheduled intervals for a few hours a day and/or several times per week as documented in an established treatment plan. Each visit by a member of the home health care team constitutes one visit. However, a visit by a home health aide is up to 4 hours of covered care.

5. Copayments. Each person covered under this Certificate is obligated to pay a copayment each time the person receives covered medical services from a Participating Physician or other Participating Provider in the office, in the person's home or in another ambulatory setting other than a hospital emergency room. However, you do not have to pay a copayment for:

- Routine well-child visits for children from the date of birth through the attainment of 19 years of age which are scheduled in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Immunizations are included.
- Maternity care visits.
- X-ray and laboratory services.
- Second surgical opinion.
- Home visits described in Paragraph 4.B. above.
- Visits exclusively for treatment of allergies.
- Chemotherapy and radiation therapy.

The amount of the copayments, which will be determined by us from time to time, is set forth on the attached Schedule of Benefits.

6. Durable Medical Equipment, Prosthetic and Orthotic Appliances, Medical Supplies. We will pay for medically necessary durable medical equipment, prosthetic and orthotic appliances, and medical supplies, which are ordered by your PCP. Durable medical equipment must be the kind used for a medical purpose, as opposed to a comfort purpose. We will determine whether the equipment should be purchased or rented. We will pay for replacement of durable medical equipment when ordered by your PCP in cases of wear, damage or changes in your condition or body structure; and we will pay for repairs and maintenance of covered equipment which has been purchased. The equipment we will pay for includes items such as: an apnea monitor, wheelchair, hospital type bed, oxygen and oxygen equipment. We will not pay for air conditioners, humidifiers, commodes, dehumidifiers, air purifiers, exercise equipment or swimming pools.

We will pay for prosthetic and orthotic appliances that replace or support all or part of a body function or organ. We will also pay for replacement, repair, fitting and adjustment of the appliances. Included, for example, are: artificial arms, legs and terminal devices (such as hands or hooks); artificial eyes, ears, nose, larynx and external breast prostheses; ostomy sets and accessories; prescription lenses when you lack an organic lens; rigid or semi-rigid supporting devices and appliances essential for the effective use of an artificial limb; corrective braces. We will not pay for arch supports, orthotics used solely for sports or myoelectric or bionic prostheses.

We will pay for medical supplies for use in connection with your illness or injury such as: surgical dressings, splints, ostomy supplies.

Common first-aid supplies are excluded.

The covered durable medical equipment, prosthetics, orthotics and medical supplies must be obtained from Participating Providers.

SECTION FIVE – CASE MANAGEMENT PROGRAM

1. Case Management. MMP will perform case management if you have a chronic debilitating or catastrophic injury or illness by providing assistance with and/or explanation of treatment decisions.

- 2. Alternative Benefits.** Notwithstanding any other provision in this Certificate, we may review your health status and your Participating Physician's plan of care to determine whether certain levels of care, providers or services which are not included in your Certificate may be desirable or appropriate.

We may make available alternative care which, in our judgment is more appropriate in place of inpatient care. The provision of these services is a substitute for the services provided in your Certificate. You may reject or discontinue our proposal of any alternative care at the time of the proposal or at any time thereafter.

You agree that we may have access to and review on a concurrent basis any of your hospital and other medical records to evaluate alternative care possibilities.

You understand and agree that any proposal of alternative care is limited to the facts and circumstances of the particular case reviewed and does not apply to any other case of yours or to any other HMO member.

- 3. Termination of Program Participation.** Either you or we may terminate participation in the Case Management Program at any time for any reason. We will give you at least ten (10) days written notice of our intention to terminate the provision of any alternative or additional care under this Section. After such termination, we will provide services, if available, to you under the terms and conditions of your Certificate.

SECTION SIX – TREATMENT OF ALCOHOLISM, SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS

- 1. Care Must be Referred by Our Mental and Behavioral Health Care Manager.** Under this Section, we will only provide coverage when you are referred for care by our Mental and Behavioral Health Care Manager. You can obtain a referral in one of two ways:

- Call the 1-800 number shown on the back of your identification card. This toll free number can be called 24 hours a day, seven days a week; or
- Call or visit your PCP. The PCP will coordinate your referral with the manager.

You must obtain the referral in writing, in advance. If you cannot do so due to an Emergency, you or a member of your family must obtain the referral within twenty-four (24) hours after you receive the care or as soon as is reasonably possible.

- 2. Mental Health Care.** We will pay for a limited number of visits for the outpatient treatment of mental and nervous conditions. The services may be provided by participating medical professionals within the scope of their practice or in the outpatient department of a Participating Hospital or other participating Facility. You must pay the amount shown on the attached Schedule of Benefits for each visit. The visit limit is also shown on the Schedule.

We will pay for inpatient psychiatric care. We will only pay for the number of days shown on the attached Schedule of Benefits. You must pay the inpatient copayment shown on the Schedule of Benefits.

- 3. Treatment of Alcoholism and Substance Abuse.** Coverage is provided for the outpatient diagnosis and treatment of alcoholism and/or substance abuse for 60 visits per person per calendar year. Up to 20 of the 60 visits may be used for family therapy. Family members eligible for family therapy are those persons covered under the same Certificate of family coverage that covers the person receiving, or in need of, treatment of alcoholism or substance abuse. Benefits for these family therapy visits are limited to one visit per day and are available even if the person in need of treatment has not yet begun that treatment. You must pay the amount shown on the attached Schedule of Benefits for each visit.

We will provide short-term inpatient care for alcoholism and/or substance abuse for 7 days per calendar year. You must pay the inpatient copayment shown on the attached Schedule of Benefits.

SECTION SEVEN – EMERGENCY CARE

- 1. Emergency Care.** We will pay for Medically Necessary care for an Emergency as defined above. If the care is received in a hospital emergency room, you must make a copayment unless you are admitted to the hospital for treatment of the same illness or injury within one day. The amount of the copayment will be determined by us from time to time and is shown on the attached Schedule of Benefits.

We will pay for Medically Necessary emergency care even if you do not call your PCP in advance. However, you or a member of your family must call your PCP or us within twenty four (24) hours after you receive care or as soon as it is reasonably possible.

We will pay for emergency care rendered by non-participating providers, including non- participating hospitals. However, if you are admitted to a non-participating hospital, we will only pay for the care for as long as we determine that the hospitalization was Medically Necessary and that your condition prevented transfer to a Participating Hospital. We can require that you be transferred to a Participating Hospital when medically appropriate.

Care received in a hospital emergency room that is not for an emergency as defined in Section One above is not covered, unless your PCP approves it.

- 2. Ambulance Service.** If in our judgment you required emergency transportation by ambulance, we will pay for the ambulance service. MMP must preauthorize transportation by an air ambulance.
- 3. Urgent Care.** Urgent care is care which is required in order to prevent serious deterioration to your health; but it is not life or limb threatening. The need for urgent care is less than the need for emergency care but it is the kind of care that needs timely attention. Examples of urgent medical problems are: bronchitis, nosebleed, fever, otitis media, sprained ankle, viral syndrome. Except as provided in the following paragraph, your PCP must provide or authorize urgent care in advance.

Urgent Care When Traveling or Visiting. We will pay for urgent care provided to you when you are traveling or visiting outside of our Service Area or are more than 100 miles away from your PCP - that is, you are temporarily out of our Service Area, or a long distance away from your PCP. When you need urgent care under these circumstances you may call the Empire member services number, which can be found on the back of your Empire identification card, for a referral to a local provider. Or you may call your PCP for prior authorization of urgent care and follow his or her instructions. We will not pay for care which, in our sole judgment, was not needed for an urgent condition.

SECTION EIGHT – HOSPICE CARE

- 1. Eligibility for Benefits.** To obtain hospice care, you must meet both of the following conditions:
 - A. Your PCP estimates your life expectancy to be six months or less.
 - B. Palliative care (pain control and symptom relief), rather than curative care, is being provided.
- 2. Hospice Organizations.** We will only pay for hospice care provided by a Participating Hospice. A Participating Hospice is a hospice which has an agreement with us to provide services to persons covered under our HMO contracts. Your admission must be authorized by your PCP, preauthorized by MMP and you must be under the care of Participating Providers while you are in the hospice.
- 3. Hospice Care Benefits.** We will pay for the following services when provided in the Participating Hospice.
 - A. Bed patient care provided by the Hospice organization either in a designated Hospice unit or in a

regular hospital bed.

- B. Day care services provided by the Hospice organization.
 - C. Home care and outpatient services which are provided and billed through the Hospice, including drugs and medical supplies. We will also pay for bereavement services provided to your family during illness, and until one year after death.
 - D. Palliative care. We will also pay for medical care outside the Hospice provided or authorized by your attending physician.
4. **Number of Visits.** We will pay for up to 210 days of hospice care, beginning with the first day on which care is provided. Each day you receive care from or through the hospice counts as a day of hospice care. We will also pay for no more than 5 visits for bereavement counseling services to your family, either before or after your death.

SECTION NINE – EXCLUSIONS

In addition to certain exclusions and limitations already described in this Certificate, we will not pay under this Certificate when any of the following apply to you:

1. **Medically Unnecessary Care.** We will not pay for any treatment, service or supply that we determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns our denial, however, we shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Certificate. (For further information on external appeals, consult your Member Handbook).
2. **Care by Non-Participating Providers.** Except in an emergency, we will not pay for care rendered by non-participating providers.
3. **Care Provided Outside of the HMO Service Area.** With the exception of emergency care and urgent care covered under Section Seven, we will not pay for services provided to you when you are visiting, traveling, or temporarily residing, outside of the 28 county HMO Service Area.. Out-of-area care is also covered under the HMO-USA Guest Membership Program (see Section Fifteen, Paragraph 13).
4. **Government Hospital.** We will not pay for care in any hospital or other institution which is owned, operated or maintained by the federal government, a state government, or any local government, unless the hospital is a participating hospital. However, this exclusion does not apply to United States Veterans Administration or Department of Defense hospitals, except for services in connection with a service-related disability. In addition, we will pay for care covered under this Certificate in such a hospital if, because of serious injury or sudden illness, you are taken to one of these hospitals for emergency care because it is close to the place where you were injured or became ill. In this type of emergency situation, we will continue to make payments only for as long as emergency care, in our sole judgment, is necessary and it is not possible for you to be transferred to another hospital.
5. **Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.

- 6. Free Care; Care Provided by Family Members.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge if you were not covered under this Certificate or under any other insurance. This also applies even if the charges are billed. We will not pay for services rendered by a member of your immediate family.
- 7. Government Programs.** We will not pay for any service which is covered, and payment is therefore available to you, under any federal, state or local government program, except that we will pay even though you are eligible for Medicaid.
- 8. Custodial Care.** We will not pay for hospital care, nursing home or skilled nursing facility care, home care or any other service which is custodial care.
- 9. Unauthorized Services.** Except for obstetrical and gynecological services described in Section Four, Paragraph 3.G. and emergency care described in Section Seven, we will not provide benefits for any service or care unless treatment is performed, or prescribed, arranged or authorized in advance, by your PCP and, when required, approved in advance by us.
- 10. Cosmetic Surgery.** No benefits are provided for any services in connection with elective cosmetic surgery or any hospitalization in connection with such surgery. However, benefits may be available for reconstructive surgery if it is necessary to treat an infection or injury. With respect to a covered child, benefits are available for reconstructive surgery to treat a functional defect resulting from a disease or anomaly that is present from birth.
- 11. Admission to a Hospital Before You Become Covered Under This Certificate.** If you are admitted to a hospital or skilled nursing facility as a registered bed patient before the date you become covered under this Certificate we will not pay for any part of your stay in that hospital or skilled nursing facility or for medical services related to that stay, to the extent that you have coverage under any other contract or policy of insurance, including provisions for benefits after termination in the event of disability. In addition, we will not pay for any part of the stay if your care is not transferred to and authorized by your PCP.
- 12. No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance. Also, we will not make any payments even if after any of the above benefits are paid, you repay them because you recover that money in a related lawsuit or other proceeding.
- 13. Dental Care.** We will not pay for dental surgery or anesthesia, or dental treatment of any kind including: treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; removal of impacted teeth; orthodontia; false teeth; treatment of dental temporo-mandibular joint syndrome, dental implants; orthognathic surgery for the purpose of aligning the teeth; or any other dental services you may receive. We will, however, pay for any service we cover under this Certificate in connection with an accidental injury to sound natural teeth if the service is performed within 12 months of the accident.
- 14. Hearing Aids.** We will not pay for hearing aids or artificial aids, including examinations for, or fitting of, the hearing or artificial aid.
- 15. Routine Care of Feet.** We will not pay for any services in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will pay for Medically Necessary capsular or bone surgery related to bunions or hammertoes. Orthotics are excluded.
- 16. We will not pay for any service, treatment or procedure in connection with any of the following:**
 - Examinations required by a third party, such as your employer, school or camp.
 - Required for a condition arising out of: participation in a felony; suicide; attempted suicide; intentionally self-inflicted injury; or war or act of war, whether declared or undeclared. However, we will pay for mental care in connection with attempted suicide.

- Weight loss counseling, except when provided by your PCP.
- Surgery for treatment of obesity for purposes of weight reduction, including gastric stapling, gastric by-pass, gastric bubble and any other surgery we determine to be medically inappropriate for treatment of obesity.

17. Eyeglasses. We will not pay for: eyeglasses; or the fitting of, or examination of the eye for, glasses or contact lenses, except when Medically Necessary, in our judgment, following cataract surgery.

18. Benefits for Medicare Eligibles Who Are Covered Under This Certificate.

- A. If your group has twenty (20) or more employees, any active employee or spouse of an active employee who becomes or remains a member of your group covered by this Certificate after becoming eligible for Medicare due to reaching age sixty-five (65) will receive the benefits of this Certificate as primary; unless Medicare is elected as the primary coverage. When Medicare is elected as primary, coverage under this Certificate will end.
- B. If your group has one hundred (100) or more employees or your group is an organization which includes an employer with one hundred (100) or more employees, any active employee, spouse of an active employee or dependent child of an active employee who becomes or remains a member of your group covered by this Certificate after becoming eligible for Medicare due to disability will receive the benefits of this Certificate as primary; unless Medicare is elected as the primary coverage. When Medicare is elected as primary, coverage under this Certificate will end.
- C. If you have end stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective, your coverage under this Certificate will be primary during the waiting period. It will also be primary during the coordination period with Medicare. After the coordination period, Medicare is primary.
- D. If you are a retiree or an active employee or spouse of an active employee who is not subject to Paragraphs A or B above and who is Medicare eligible you will continue to receive the benefits of the Certificate. We will file the appropriate forms with Medicare so that the Medicare benefits will be applied to defray the premium cost of the HMO program. You must enroll in Medicare, sign any claim forms or other documents which are necessary for us to obtain payments from Medicare for services provided to you through the HMO. If you do not enroll or do not sign the forms or other documents and submit them to us, we have the right to deny HMO payments for the service.

19. Treatments, Procedures, Hospitalization, Drugs, Biological Products or Medical Devices Which are Experimental or Investigational.

We will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology") or any hospitalization in connection with such technology if, in our sole discretion, it is not Medically Necessary in that such technology is experimental or investigational. Experimental or investigational means that \ the technology is:

- A. not of proven benefit for the particular diagnosis or treatment of your particular condition; or
- B. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

We will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

We may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

- any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.
- conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
- demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable;
- proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

This exclusion does not apply to cancer drugs as required by Section 4303(q) of the New York State Insurance Law.

However, we shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Certificate for non-experimental or non- investigational treatments provided in such clinical trial. (For further information on external appeals, consult your Member Handbook.)

- 20. Donor Fees; Transportation.** We will not pay for donor fees and transportation costs in connection with non-experimental organ transplants.
- 21. Drugs.** We will not pay for prescription drugs, over-the-counter drugs which do not require a prescription, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication except drugs provided on an inpatient basis or pursuant to Section Four, Paragraph 3.F. and diabetes equipment and supplies pursuant to Section Four, Paragraph 3.J.
- 22. Pre-existing Conditions.** We will not pay for any pre-existing conditions until you have been enrolled under this Certificate for at least 11 consecutive months. A pre-existing condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on your enrollment date under this Certificate. For purposes of this section, “enrollment date” means the first day of your coverage under this Certificate or, if earlier, the first day of any waiting period that must pass before you are eligible to be covered for benefits under this Certificate.

Genetic information will not be treated as a pre-existing condition unless you have been diagnosed with a condition related to such information.

This exclusion for pre-existing conditions does not apply:

- A. If, on the last day of the 30 day period beginning on the date of birth, you are covered under Creditable Coverage as defined below.

- B. To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30 day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage as defined below.
- C. In the case of pregnancy.

Paragraphs A and B will not apply after the end of the first 63 day period during all of which you were not covered under any Creditable Coverage.

“Creditable Coverage” means your coverage under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or B of title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under chapter 89 of title 5, United States Code;
9. A public health plan (as defined in regulations);
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). In determining whether this pre-existing condition provision applies, we will credit the time you were previously covered under Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than 63 days prior to your enrollment date under this Certificate. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective will also be credited.

This exclusion does not apply if your group has more than 50 members.

- 23. Services of Unlicensed Providers.** We will not pay for services provided by an unlicensed provider or services that are outside the scope of the license of a licensed provider.
- 24. Private Duty Nursing Services.** We will not pay for private duty nursing services.
- 25. Assisted Reproductive Technologies.** We will not pay for reversal of sterilization or artificial insemination. Also excluded are: in-vitro fertilization; gamete intrafallopian tube transfer; zygote intrafallopian tube transfer; intracytoplasmic sperm injection; or other forms of assisted reproductive technology, unless otherwise required by law. We will not pay for cryopreservation of sperm or embryos.
- 26. Services by Employees of Facilities.** We will not pay for services performed by staff employed by a Hospital or other Facility where you receive care.

SECTION TEN – COORDINATION OF BENEFITS

- 1. Applicability.** This Section applies only to subscribers and members of their families covered under “THIS PLAN” who also have group health benefits coverage with another “Plan.” (The terms “THIS PLAN” and “Plan” are defined below.) When that is the case and you receive an item of service, we will coordinate benefit payments with any payment made under the other Plan. One will pay its full benefit as the primary plan and the other may pay secondary benefits, if necessary, to cover some or all of your remaining expenses. This prevents duplicate payments and overpayments.
- 2. Definitions.**
 - A. “THIS PLAN” is this certificate of coverage.
 - B. “Plan” is another group health benefits program with which we will coordinate benefits. The term “Plan” includes:

- Group health benefits and group, blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid group coverage but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premium.
- Medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.
- Hospital, medical and surgical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. It also does not include any plan whose benefits are by law excess to any private insurance program or other non-governmental program.

3. Rules to Determine Payment. The first of the rules listed below (A-F) which applies shall determine which plan shall be primary:

- A. If the other Plan does not have a provision similar to this one, then it shall be primary.
- B. If you, the person receiving the benefits, are the person belonging to the group through which, or to which, THIS PLAN was issued and you are only covered as a dependent under the other Plan, THIS PLAN will be primary.
- C. If a dependent child is covered under plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. For purposes of determining whose birthday falls earlier in the year, only the month and date are considered. However, if the other Plan does not have this (“birthday”) rule but instead has a rule based on the gender of the parent and as a result the plans do not agree on which is primary, then the father’s plan shall be primary.
- D. If a dependent child is covered by both parents’ plans, the parents are separated or divorced and there is no court decree which establishes financial responsibility for the child’s health care expenses:
 - i. the plan of the parent who has custody (the custodial parent) shall be primary;
 - ii if the custodial parent has remarried, and the child is also covered as a dependent under the stepparent’s plan, the custodial parent’s plan shall pay first, the stepparent’s plan second and non-custodial parent’s plan third.

If a court decree specifies which parent is to be responsible for the child’s health care expenses and that parent’s plan has actual knowledge of the decree, then that parent’s plan shall be primary.

- E. If you are covered under one plan as an active employee (e.g., not laid-off or retired), or as the dependent of such an active employee and you are covered under another plan as a laid-off or retired employee or as the dependent of such a laid-off or retired employee, the plan which covers you as an active employee, or as the dependent of such an active employee, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
- F. If none of the above rules determines which plan shall be primary, the plan which covered you for the longer period of time shall be primary.

4. Effects of Coordination. When THIS PLAN is secondary, the benefits of THIS PLAN will be reduced by the amount paid or provided by the primary plan(s) for the same item of service. The amount THIS PLAN will pay or provide will not be more than the amount it would pay or provide if it were primary. The benefits of THIS PLAN plus those of the primary plan will be less than your total expenses for an item of service unless the primary plan by itself provides benefits at 100% of your expenses.

5. Private Room Differential. Regardless of whether THIS PLAN is primary or secondary, THIS PLAN will not pay or provide benefits for the difference between the cost of a private hospital room and the cost of a semi-

private hospital room unless a private room is Medically Necessary in terms of generally accepted medical practice and covered under Section Three, Paragraph 4 of this Certificate.

6. **Right to Receive and Release Necessary Information.** We have the right to release or obtain information which we need to carry out the purpose of this Section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not, we have the right to deny payments to you.
7. **Payments to Other Plans.** We may repay to any other plan the amount which it paid for your expenses and which we decide we should have paid. These payments are the same as benefits paid to you and they satisfy our obligation to you under THIS PLAN.
8. **Our Right to Recover Overpayment.** In some cases we may have made payment even though you had coverage under another plan. Under these circumstances, you agree to refund to us the amount by which we should have reduced the payment we made. We also have the right to recover any overpayment from the other plan and you agree to sign all documents necessary to help us recover any overpayment.
9. **Coordination with "Always Excess," "Always Secondary" or "Non-Complying" Plans.** We will coordinate benefits with plans which provide benefits which are always excess or always secondary or use order of benefit determination rules which are inconsistent with those described above ("non-complying plans") in the following manner:
 - A. If THIS PLAN is primary, it will pay or provide benefits first;
 - B. If THIS PLAN is secondary, we will still pay or provide benefits first, but the amount paid or benefits provided will be limited to what we will pay or provide if we were secondary; and
 - C. If we request information from a non-complying plan and do not receive it within 30 days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying plan and THIS PLAN provide identical benefits. When the information requested is received, we will make the necessary adjustments.

SECTION ELEVEN – PREMIUMS FOR THIS COVERAGE

1. **Amount of Premiums.** The premiums for this coverage are determined by us from time to time. The premiums must also be approved by the Superintendent of Insurance of the State of New York. The premiums may vary for the different geographic regions served by the HMO. If you move from one region to another or change PCPs the premium rate for your coverage may change.
2. **Change in Premiums.** If there is to be either an increase or a decrease in the premiums for this coverage, we will give you written notice that there will be a change at least 15 days before the new premiums go into effect.
3. **Payment of Premiums and Grace Period.** All premiums for this coverage are due in advance. However, we allow a 15 day grace period for the payment of all premiums, except the first premium. This means that, except for the first premium, if payment is made to us within 15 days of the date the payment was due, we will continue coverage under this Certificate for the entire period covered by the payment. If payment is not made within the 15 day grace period, your coverage under this Certificate will terminate as of the date to which premium was paid. You will not become covered under this Certificate until the first premium payment has been paid to us.

SECTION TWELVE – TERMINATION OF YOUR COVERAGE

Described below are reasons why your coverage under this Certificate may terminate.

1. **Default in Payment of Premiums.** Your coverage will automatically terminate as of the date to which the premium was paid if we do not receive your premium by the end of the 15 day grace period. If the premium is not paid by the end of the 15 day grace period, we will not make payments under this Certificate for any service given to you after the date to which the premium was paid. For example, if the premium is due on June 1 and it is not paid by June 15, the end of the 15 day grace period, and premium was paid to June 1, no payment will be made under this Certificate for any services given to you after June 1. However, if you are totally disabled on the date your coverage terminates you may be entitled to have your benefits continued (see Paragraph “8” below). If you receive care from a Participating Physician following the date your coverage terminates, you must pay the physician at his or her normal charges.

If Empire accepts your payment after you have failed to make a timely premium payment and the grace period has expired, your contract will be reinstated, but only to cover such sickness and injury as may be first manifested more than ten days after the date of such acceptance.

Reinstatement Fee. At our sole option we may reinstate your coverage after it has terminated due to non-payment of premium. If we decide to reinstate your coverage, we reserve the right to charge a reinstatement fee in addition to requiring that all outstanding premiums be paid. Reinstatement of your coverage on one occasion does not apply to any other case of yours or any other HMO member.

2. **If You are No Longer Covered in a Group.** This coverage will terminate on the date indicated if one of the following happens:
 - A. On the date to which your premium is paid if you are no longer a member of the group. For example, if your employment in the group terminates on May 15 and your premium has been paid to June 1, this coverage will terminate on June 1.
 - B. On 30 days prior written notice if the size of your group no longer meets our requirements. We will notify you if this happens. For example, if we notify you on May 15 that the size of your group no longer meets our requirements, this coverage will terminate on June 15.
 - C. On the date to which your premium is paid if your employer, or other organization which sends your premium to us, tells us it will no longer send in the premiums for the group. For example, if we are notified by your employer on May 15 that the employer will no longer send in your premium and your premium is paid to June 1, this coverage will terminate on June 1.
3. **When you Become Eligible for Medicare.** Coverage of any person under this Certificate will automatically terminate if under the Tax Equity and Fiscal Responsibility Act of 1982, or the Omnibus Budget Reconciliation Act of 1986, and subsequent amendments you have an option to either remain covered by this Certificate or be covered by Medicare, and you elect Medicare as the primary coverage.
4. **On Your Death.** Coverage will automatically terminate on the date of your death. However, if you have family coverage, this coverage will terminate on the date to which the premium has been paid.
5. **Termination of Your Marriage.** If you become divorced or your marriage is annulled, the coverage of your wife or husband will automatically terminate on the date of the divorce or annulment.
6. **Termination of Coverage of a Child.** The coverage of your child under this Certificate will automatically terminate when the child marries, becomes the age shown on the Schedule of Benefits, whichever comes first, or is no longer an unmarried full-time student under the age shown on the Schedule of Benefits at an accredited institution. The coverage will terminate as of December 31st of the calendar year in which the child

no longer meets these conditions, or date of marriage, whichever occurs first.

If the child is covered under Section Two of this Certificate because the child is unable to work or support himself, coverage will terminate on the date the child is no longer incapable of self-support.

- 7. Termination and Nonrenewal.** Except as described above, your coverage under this Certificate will be renewed and continued in force. However, we may nonrenew or discontinue coverage under a group contract based only on one or more of the following:
- A. The contract holder or participating entity has failed to pay premiums or contributions in accordance with the terms of the contract or we have not received timely premium payments.
 - B. The contract holder or participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
 - C. We cease to offer group or blanket policies in a market in accordance with this provision.
 - D. The contract holder ceases to meet the requirements for a group under Section 4235 of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the policy is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.
 - E. Where we offer a group policy in a market through a network plan, there is no longer any member in connection with such plan who lives, resides or works in our Service Area.
 - F. Such other reasons as are acceptable to the Superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104- 191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

In any case where we decide to discontinue offering a particular class of group HMO contract offered in the small or large group market, the contract of such class may be discontinued if:

- 1. We provide written notice to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety days prior to the date of discontinuance of such coverage.
- 2. We offer to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other HMO coverage currently being offered by us to a group in such market.
- 3. In exercising the option to discontinue coverage of this class and in offering the option of coverage under item 2 above, we act uniformly without regard to claims experience of those contract holders or any health status - related factor relating to any members covered or any new members who may be eligible for coverage.

In any case in which we elect to discontinue offering all HMO coverage in the small group market or the large group market, or both markets, in the state, coverage may be discontinued only if:

- 1. We provide written notice to the Superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage.
- 2. All HMO coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and

3. We provide the Superintendent with a plan to minimize potential disruption in the marketplace occasioned by the discontinuance.

At the time of coverage renewal, we may modify the health insurance coverage for a group contract offered to a large or small group contract holder so long as such modification is consistent with New York State Insurance Law and effective on a uniform basis among all small contract holders with the contract form. The coverage renewal date is the anniversary of the effective date of the group contract.

8. **Benefits After Termination.** If you are, in our sole judgment, totally disabled on the date your coverage under this Certificate terminates, and you receive service or care for the illness, condition or injury which caused your total disability, we will continue to pay for your care under this Certificate during an uninterrupted period of total disability until the first of the following dates:

- A. A date you are, in our sole judgment, no longer totally disabled.
- B. A date twelve months from the date this Certificate terminates or your coverage under this Certificate terminates.

However, we will not pay for more than you would have been entitled to receive if your coverage under this Certificate had not terminated; and we will not provide benefits after termination if you have coverage for the total disability under another group plan.

9. **Temporary Continuation of Coverage.** Under the continuation of coverage provisions of the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most group health plans sponsored by employers with 20 or more employees must offer employees and their dependents the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If you are not entitled to temporary continuation of coverage under COBRA (for example, because your employer has less than 20 employees) you may be entitled to continuation of coverage under the provisions of the New York State Insurance Law as described in Paragraph 10 below. Call or write your employer or us to find out if you are entitled to continuation of coverage under COBRA or under the New York State Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York State Insurance Law.

10. **Continuation of Coverage Under New York State Insurance Law.** If you lose coverage under this Certificate because of termination of employment or membership in the class or classes eligible for coverage, you may continue coverage for yourself and your eligible dependents subject to the following conditions:

- A. You are not entitled to Medicare; and you are not covered under or eligible for other group coverage which does not exclude or limit coverage for pre-existing conditions.
- B. You must request continued coverage within 60 days after the later of: the date of termination; or the date you are given notice of continuation by the group. If you wish continuation under Div. below, you must notify the group within 60 days after a determination that you were disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage.
- C. You must pay the premium (not more frequently than monthly) when due. The first payment is due within 60 days after the date coverage would otherwise terminate. The premium cannot exceed 102% of the group's rate.
- D. Coverage will terminate at the earliest of the following:
 - i. The date 18 months after your coverage would have terminated because of termination of employment or membership.
 - ii. The date to which premiums are paid if you fail to make a timely payment.
 - iii. If you are an eligible dependent, the date 36 months after coverage would have terminated due

- to: death of the employee or member; divorce or legal separation; the employee or member's eligibility for Medicare; failure to qualify under the definition of "children."
- iv. The date 29 months after coverage would have otherwise terminated because of termination of employment or membership if the employee or member is determined to have been disabled under the Social Security Act at the time of termination of employment or membership or at any time during the first 60 days of continuation of coverage. However, if the employee or member is no longer disabled, coverage will terminate at the later of: the date in "i" above; or the month that begins more than 31 days after the determination that the employee or member is no longer disabled.
 - v. The date the group no longer provides coverage to any of its employees or members.

11. The Right To Convert Coverage When Continued Coverage Ends. When continued coverage ends, coverage may be converted according to Section Thirteen.

12. Supplemental Continuation and Conversion. If your group's plan qualifies as an employer group health plan subject to the federal continuation of coverage provisions of COBRA as described above in Paragraph 9, the supplementary continuation and conversion rights described in this paragraph do not apply.

If you are a member of a reserve component of the armed forces of the United States, including the National Guard, and enter active duty and you do not voluntarily maintain HMO coverage, coverage shall be suspended unless you elect in writing, within sixty days of being ordered to active duty, to continue coverage under this Certificate for yourself and your eligible dependents. Such continued coverage shall not be subject to evidence of insurability. You must pay the group the required group-rate premium in advance, but not more frequently than once a month.

Supplementary continuation shall 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 shall not be considered group coverage for the purposes of this paragraph.

In the event that you are re-employed or restored to participation in the group upon return to civilian status after the period of continuation of coverage or suspension, you shall be entitled to resume coverage under this Certificate for yourself and your eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion shall 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.

In the event that you are not re-employed or restored to participation in the group upon return to civilian status, you shall have the right within thirty-one 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 year, to submit a written request for continuation to the group, or a request for conversion directly to the HMO, as described elsewhere in the Certificate. Such individual conversion policy shall be effective on the day after the end of the period of supplementary continuation. If you elect supplementary continuation or if coverage is suspended, the supplementary conversion right shall be available to your spouse if divorce or annulment of the marriage occurs during the period of active duty, and, in the event you die while on active duty, to your spouse and children, and to each child individually upon attaining the limiting age of coverage under this Certificate (but not the child's dependents).

SECTION THIRTEEN – RIGHT TO NEW CONTRACT AFTER TERMINATION

If coverage under this Certificate terminates, then under the circumstances described below you may continue coverage with us by purchasing a new contract.

- 1. If You Are No Longer Covered in a Group; or If the Group Defaults in the Payment of Premium.** If coverage terminates under the provisions of Paragraphs "1" or "2" of Section Twelve because your group defaults in the payment of premium or you are no longer a member of a group, you are entitled to purchase a new

contract as a direct payment subscriber unless the group has replaced the coverage with similar and continuous coverage.

2. **On Your Death.** If coverage terminates because of your death, your wife or husband or dependent children are entitled to purchase a new contract as a direct payment subscriber.
3. **Termination of Your Marriage.** If your coverage terminates because you become divorced or your marriage is annulled, you are entitled to purchase a new contract as a direct payment subscriber.
4. **Termination of Coverage of a Child.** If your coverage terminates because you become married, reach the age shown on the Schedule of Benefits, or are no longer an unmarried full-time student under the age shown on the Schedule of Benefits, or if you are no longer incapable of self-support, you are entitled to purchase a new contract as a direct payment subscriber.
5. **When To Apply For The New Contract.** If you are entitled to purchase a new contract, you must apply to us for the new contract within 45 days after notice of termination of coverage under this Certificate is given; or if no notice is given, within 90 days of termination. You must also pay the first premium for the new contract within this same 45 or 90 day period.
6. **The New Contract.** The new contract will be the standardized HMO contract required to be sold on a direct payment basis. If you prefer, the new contract will be the standardized HMO contract with out-of-plan benefits.

SECTION FOURTEEN – DISPUTES UNDER THIS CERTIFICATE

1. **Appeals.** If you are subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have certain rights and protections and your group may have duties as the Group Health Plan Administrator. Among them are the right to appeal a claim decision.

Under ERISA, 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. Then you have sixty (60) days to appeal our decision. You (or your authorized representative) may submit a written request for review. 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 sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one hundred and twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

You may also refer to your Member Handbook for a description of the HMO complaint procedures, including appeals to the HMO Grievance Committee. These procedures apply whether or not you are subject to ERISA.

Medical Management Program Appeals

If we have not made and notified you of an adverse determination, as defined by law, within the specified timeframes, you may request an internal review without waiting for us to make the determination. Also, if you have requested an internal review of an adverse determination, and we have not made and notified you of our review decision within specified timeframes, we are required to cover the service, subject to all other conditions of your coverage.

External Appeals

You have the right to an external appeal of a final adverse determination by Empire that is based on a determination that the requested service is not medically necessary, or that the requested service is experimental or investigational. You do not have the right to an external appeal of any other determination, even if those other determinations affect your coverage. You may request an external appeal only if the requested service is a covered service under this Contract or Certificate.

- An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal.
- You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.
- You may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination. You or your physician may obtain additional standard request forms at any time from the state Insurance Department, the Department of Health, or by contacting us.
- You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination or within 45 days of receiving a letter from us waiving our internal review process. We do not have the authority to grant extensions of this deadline.

External Appeals Based on Medical Necessity. You may request an external appeal if the final adverse determination indicates that the requested service is not medically necessary.

External Appeals for Determinations Involving Experimental or Investigational Treatment. In order to request an external appeal under this Paragraph, your attending physician must certify that you have a life-threatening or disabling condition or disease. A ‘life-threatening condition or disease’ is one that, according to the current diagnosis of your attending physician, has a high probability of causing your death. A ‘disabling condition or disease’ is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

In addition, your attending physician must certify: that standard health services or procedures have been ineffective, or would be medically inappropriate in treating your life-threatening condition or disease; or that no more beneficial standard treatment exists which is a covered service under your plan.

Your attending physician must have recommended a health services or procedure (including off-label usage of a pharmaceutical product), which, based on at least two documents from the available medical literature, is likely to be more beneficial to you than any standard covered health service or procedure. To make this recommendation, your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

External Appeals of Determination Involving Clinical Trials. In order to request an external appeal under this Paragraph, your attending physician must certify that you have a life-threatening or disabling condition or disease as described above. In addition, your attending physician must certify that a clinical trial for your condition exists and that you are eligible to participate in the clinical trial. Your attending physician must also recommend that you participate in the clinical trial. To make this recommendation, your attending physician must be board certified or board eligible and qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

The clinical trial for which you are requesting coverage must be peer-reviewed, reviewed and approved by a qualified Institutional Review Board, and approved by one of the following:

- the National Institutes of Health (NIH), an NIH cooperative group or NIH center, the Food and Drug Administration or the Department of Veterans Affairs;
- an entity that has been identified by the NIH as a qualified non-governmental research entity; or
- an Institutional Review Board of a facility that has multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

Effect of the External Appeal Agent's Decision; Coverage. The decision of the External Appeal Agent is binding on both parties. If the External Appeal Agent decides in our favor, we will not cover the requested service. If the External Appeals Agent decides in your favor, we will cover the service as follows:

- for services denied as not medically necessary, we will treat the service as medically necessary and provide coverage subject to all other conditions of your coverage.
- for services denied as experimental or investigational, other than services provided in a clinical trial, we will pay for the patient costs you incur for the services, subject to all other conditions of coverage.
- for services denied as experimental or investigational that are provided in a clinical trial, we will cover the costs of health services required to provide treatment according to the design of the trial, subject to all other conditions of coverage. We are not required to pay for and will not pay for, drugs and devices that are the subject of the clinical trial.

We will not provide coverage for any service that is not a covered service under your Certificate. All other terms of your certificate apply to this section, including any applicable copayments, coinsurance or deductibles.

2. **Choice of Law.** This Certificate has been issued in New York State pursuant to our contract with a group located in New York State. In any dispute between us and the group or you, New York or federal law, as appropriate, shall be applied to determine your rights, the rights of the group, and our rights.
3. **Time To Bring Legal Action; Option of Arbitration.** You must start any lawsuit against us under this Certificate within two years from the date you receive the service for which you want us to pay.

If you would prefer an arbitration proceeding rather than a legal action, we hereby consent to have any and all disputes you may have arising out of, or related to, this Certificate submitted to arbitration under the conditions described below, rather than a court of law. The arbitration shall be conducted pursuant to the rules of the American Arbitration Association. The cost of the arbitration shall be borne equally between you and us. We hereby agree, and you must agree if you choose to initiate the arbitration proceeding, to be bound by the decision of the arbitrator and consent to have judgment upon the arbitration award be entered in any court of competent jurisdiction. The arbitration must be conducted in New York State and according to New York law. You must start any arbitration proceeding against us under this Certificate within two years from the date you received the service which you want us to pay for. The arbitration provision offered in this paragraph is made available under special provisions of the Insurance Law which allow innovative health care coverage to be offered on an experimental basis. Under the Insurance Law this arbitration provision may be terminated at any time, when authorized or required by the Superintendent of Insurance. However, termination of this arbitration provision shall not alter or affect the validity of any decision issued by an arbitrator, or the validity of arbitration procedures already initiated by filing a demand for arbitration, prior to the date any such termination is designated to take effect.

SECTION FIFTEEN – GENERAL PROVISIONS

1. **No Assignment.** You cannot assign any benefits or monies due under this Certificate to any person, corporation or other organization. Any assignment by you will be void. assignment means the transfer to another person or to an organization of your right to the services provided under this Certificate or your right to collect money from us for those services.
2. **Notice.** Any notice which we give to you will be mailed to you at your address as it appears on our records, or if you are covered in a group, in care of your employer or other organization which sends the premium to us. If you have to give us any notice, it should be mailed to our office at Empire HealthChoice HMO, Inc., Church Street Station, P.O. Box 3509, New York NY 10008-3509.

- 3. Your Medical Records.** In order to provide care, address your concerns, respond to grievances, perform utilization review or quality assurance activities or process your claims under this Certificate, it may be necessary for us to obtain your medical records and information from hospitals, skilled nursing facilities, doctors or other practitioners who treated you. When you become covered under this Certificate, you automatically give us permission to obtain and use those records and that information. If you do not furnish us with the records, we have the right to deny payment for that claim.

At any time requested by us, you will provide us with a signed authorization to obtain records we need as referred to above. You hereby authorize us to disclose to a hospital or health care service plan, self-insurer or insurer, any medical information obtained or payments made if such disclosures are necessary to allow the processing of any claim.

You also authorize disclosures to your employer, trust fund, union or similar entity which arranged for this coverage for purposes of utilization review or audit and such disclosures as may be permitted or required by law.

- 4. Changes To This Certificate.** We may change this Certificate at the time the group contract is renewed. We will give you at least 30 days written notice of any change. All care you receive after the effective date of the change will be subject to the change, even if you were receiving care before the change became effective.
- 5. Who Receives Payment Under This Certificate.** Payments under this Certificate for service provided in a participating hospital or by a Participating Physician or Provider will be made by us directly to the Hospital, physician or provider. If you receive service in a non-participating hospital, or from any other provider of care covered under this Certificate, we reserve the right to pay either you or the hospital, or other provider.
- 6. Recovery of Overpayments.** On occasion a payment will be made when you are not covered, for a service which is not covered, or which is more than is proper. When this happens we will explain the problem to you and you must return to us within 60 days the amount of the overpayment.
- 7. Furnishing Information and Audit.** The group and all persons covered under this Certificate agree to promptly furnish us all information and records which we may require from time to time to perform our obligations under this Certificate. You also agree to provide us with information over the telephone for reasons like the following: to allow us to determine the level of care you need; so that we may certify care authorized by your PCP; or to make decisions regarding the medical necessity of your care. The group agrees that upon reasonable notice it will make available to us, and we may audit and make copies of, any and all records relating to group enrollment at the group's New York office.
- 8. Enrollment.** The group further agrees to develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all persons covered under this Certificate, and any other information required to confirm their eligibility for coverage. The group agrees to provide us with the Notice of Election including your name, address, age, and social security number and to advise us in writing when you are to be added to or subtracted from our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date the group's contract with us. If the group fails to so advise us, the group will be responsible for the cost of any claims paid by us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 60 days.
- 9. This Certificate Does Not Change a Provider's Usual Procedures.** This Certificate does not change the relationship between a patient and provider or hospital and it does not force a provider or hospital to accept you as a patient. Usual hospital rules apply to the services you receive. We do not guarantee admission to any hospital or that any particular service or accommodation will be available.
- 10. Physical Examination.** We may require you to undergo a physical examination as often as reasonably necessary in connection with any injury or illness which results in a claim under this Certificate.

- 11. Right To Develop Guidelines and Group Administrative Rules.** We may develop or adopt standards which describe in more detail when we will or will not make payments under this Certificate and group administrative rules pertaining to group enrollment and other administrative matters. We have all the powers necessary or appropriate to enable us to carry out our duties in connection with the administration of this coverage, including, without limitation thereto, the power to construe this Certificate, to determine all questions arising under it, and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Certificate. If you have a question about the standards which apply to a particular benefit or the group administrative rules, you may contact us and we will explain the standards or rules.
- 12. Independent Licensee.** Empire HealthChoice HMO, Inc. (Empire) is an independent health maintenance organization organized under the laws of New York State. Empire also operates under licenses with the Blue Cross and Blue Shield Association, the association of independent Blue Cross and Blue Shield plans, which licenses Empire to use the Blue Cross and Blue Shield Service Marks in a portion of New York State. Empire does not act as an agent of the Blue Cross and Blue Shield Association, and Empire is solely responsible for honoring its agreements to provide comprehensive health services plans to its customers.
- 13. Guest Membership.** If you are away from our Service Area for an extended period of time, you may be eligible for Guest Membership at a local HMO which is part of the Blue Cross and Blue Shield Association's national HMO network. Spouses and dependent children must be away for at least 90 days. The Certificate holder must be away at least 90 days, but not more than 180 days. You will have the benefits offered by the local ("Host") HMO, but at no extra charge. Call the Empire member services number on the back of your Empire identification card for information about the Guest Membership program.
- 14. BlueCard Program.** We participate in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. The BlueCard Program gives our members access to care when outside of our Service Area. By presenting your identification card to any Blue Cross and/or Blue Shield participating hospital, physician or other provider outside of our Service Area anywhere in the United States, you are assured that you will receive the covered services you would be entitled to receive within our Service Area and that you will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan. HMO members, however, remain subject to Certificate limitations that apply to coverage outside the Service Area. Member liability for covered services for claims incurred outside our Service Area and processed through the BlueCard Program, in most instances, will be based on the lower of:
- The out-of-area participating provider's actual billed charges for the covered services provided, or
 - The negotiated price for the covered services that the out-of-area Blue Cross and/or Blue Shield Plan passes on to us.

The "negotiated price" will generally consist of (a) a simple discount to the participating provider's billed charge; or (b) an estimated final price that factors in expected settlements or other non-claims transactions with the out-of-area provider or specified group of providers; or (c) a discount from billed charges that reflects average expected savings. Plans which use estimated or average prices may also periodically adjust their future estimated or average prices to correct for over- or underestimation of past prices.

Some Blue Cross and/or Blue Shield Plans charge an access fee for making their negotiated rates and the resulting savings available on claims processed through the BlueCard Program. This fee is not included in the negotiated price that is the basis for member liability, but rather is paid by us when the claim is finalized.

In addition, laws in a few states require Blue Cross and/or Blue Shield Plans to calculate member liability for covered services based on a method that does not reflect the entire savings realized or expected to be realized on a particular claim. Thus, when our members receive covered services in those states, their member liability for covered services will be calculated using the applicable state's statutory methods.



EMPIRE HEALTHCHOICE HMO, INC. PRESCRIPTION DRUG RIDER

The Contract or Certificate to which this Rider is attached is amended and the prescription drug coverage is deleted and replaced with the coverage set forth in this Rider. This Rider increases the coverage provided under your HMO Certificate or Contract.

1. Prescription Drugs. We will pay for those FDA approved drugs which require a prescription. Prescription drug coverage is also available for:

- Insulin and related supplies and equipment
- Infertility drugs
- Self-administered injectables
- Medically necessary enteral formulas for which a physician or other health care provider licensed to prescribe under Title 8 of the New York Education Law has issued a written order. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific form of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic physical disability, mental retardation, or death, if left untreated. We will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such a written order. However, our coverage for modified solid food products is limited to \$2,500 for any continuous period of 12 months.
- **Bone density drugs and devices or generic equivalents approved as substitutes.**

We will not pay for oral contraceptive drugs when prescribed for birth control. However, we will pay for these same drugs as follows: when medically necessary for the treatment of another health condition; and your provider obtains our preauthorization for the drug to be prescribed.

EMPIRE HEALTHCHOICE HMO, INC. utilizes a drug formulary which is a list of high quality, preferred, pharmaceutical products. Your doctor is encouraged to prescribe prescription drugs from the drug formulary.

We will only make payments when the drug is prescribed for your use outside of a hospital. The prescription order must be issued by a prescriber legally authorized to issue the prescription order. The prescription order must be filled by a licensed pharmacist in a retail pharmacy licensed by the state.

We will only make payments at a pharmacy which is a member of our Pharmacy Network. A pharmacy which is a member of our Pharmacy Network is one which has entered into an agreement to provide prescription drug benefits to the persons covered by this Rider.

If the prescription is filled outside of our Service Area, the pharmacy must be a member of the National network with which we have an agreement.

When you have a prescription filled you must pay the pharmacy the Copayment of each separate prescription or refill. We will pay the pharmacy directly for the remainder of the cost of the prescription or refill.

The amount of the Copayment for your prescription drug coverage is listed in the schedule of benefits.

We will pay for no more than a 30-calendar day supply of the drugs on each occasion when you have the prescription filled or refilled.

We will not pay for refills which occur more than a year after the prescription order was originally issued to you; even though the prescription order may still be valid at that date.

Whenever you have your prescription filled you must present your Prescription Drug Identification Card to the pharmacy in order for the prescription to be covered by this Rider.

2. **Mail Order Prescription Drugs.** We will also pay for those FDA approved, maintenance drugs which require a prescription, through our mail order participating pharmacy. Other drugs may also be purchased at mail order. Mail order prescription drugs may be dispensed in up to a 90 consecutive day supply. You will be required to pay two Copayments for each supply between 31 days and 90 days. You will be required to pay one Copayment for each 30 day or less supply.

The maintenance drug list is updated periodically. Call the customer service number on the back of your ID card to find out if a particular drug is on the maintenance list. You can also purchase maintenance drugs at a participating retail pharmacy for up to a 90 day supply, but you will be required to pay one Copayment for each 30 day supply.

We will only make payment at our participating mail order pharmacy. This is a mail order pharmacy which has entered into an agreement to provide prescription drug benefits to the persons covered by this Rider.

We will not pay for refills more than a year after the prescription was issued.

3. Copayments for Brand Name Drugs, Generic Drugs and Non-Formulary Drugs.

Empire uses a Preferred Formulary which is a list of brand and generic prescription drugs. This list is distributed to participating pharmacies and is subject to periodic review and modification by us.

You must pay the Copayment for prescription brand drugs whether or not there is a generic equivalent available on Empire's Formulary. The amount of the brand Copayment is listed on the schedule of benefits.

You must also pay the non-formulary Copayment for drugs, whether brand or generic, which are not on our formulary.

The Copayments for generic drugs, brand drugs, and non-formulary drugs are listed on the schedule of benefits.

Copayments do not apply to any Deductible requirements of this Rider.

These benefits may be subject to a Deductible chosen by your group. However, the Deductible will not apply if your prescription drugs are purchased through our participating mail order pharmacy.

4. Additional Exclusions and Limitations. The additional exclusions listed below apply to this Rider. Under this paragraph we will not pay for:

- a. Administration or injection of any drugs.
- b. Appetite suppressants will only be covered when prescribed by a physician to treat a medically necessary condition.
- c. Replacement resulting from loss, theft or breakage.
- d. Devices of any type such as therapeutic devices including diaphragms, IUDs, and Norplant, artificial appliances, hypodermic needles, syringes or similar devices except where specifically covered and except for bone density testing and treatment devices.
- e. Drugs that are considered to be experimental or investigational, as more fully defined in the Certificate or Contract to which this Rider applies unless recommended by an External Appeal Agent. Please see your handbook for more information on the external appeals process. However, coverage will not be excluded for a prescription drug that is approved by the Federal Food and Drug Administration (FDA) for treatment of cancer when the drug is

prescribed for a different type of cancer than the one for which FDA approval was obtained. However, the drug must be recognized for treatment for the type of cancer for which it has been prescribed in one of the following publications:

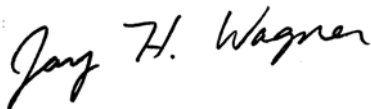
- (1) the American Medical Association Drug Evaluations;
- (2) the American Hospital Formulary Service Drug Information;
- (3) the United States Pharmacopia Drug Information; or
- (4) it is recommended by a clinical study or review article in a major peer-reviewed Professional journal.

Notwithstanding the provisions of this section, coverage shall not be required for any experimental or investigational drug or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Any benefits provided pursuant to this section shall be provided to the same extent as other benefits under the policy for drugs prescribed for treatments approved by the Food and Drug Administration.

- f. Medications for cosmetic purposes only, except that medications shall be covered for medically diagnosed congenital defects and birth abnormalities and for any other conditions for which a medication is medically necessary.
- g. Vitamins which by law do not require a prescription.
- h. Drugs dispensed to you while a patient in a hospital, nursing home or other institution.
- i. Smoking cessation products, except that those products shall be covered whenever they are medically necessary.
- j. Over the counter drugs.
- k. Oral contraceptives, unless prescribed for purposes other than birth control.

The Copayments for generic drugs, brand drugs, and non-formulary drugs are listed on the Schedule of Benefits.

- 5. Other Provisions.** All of the terms, conditions and limitations of your Empire HealthChoice HMO, Inc. Contract or Certificate to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC. RIDER TO YOUR CONTRACT OR CERTIFICATE

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below.

The description of the Preferred Drug Formulary in your Prescription Drug Rider is deleted and replaced by the following:

Empire uses a Preferred Formulary, which is a list of generic and preferred brand drugs that is distributed to participating pharmacies and providers and is subject to periodic review and modification by us. The Covered Person's doctor is encouraged to prescribe generic-equivalent drugs as appropriate when possible and to prescribe drugs from the Preferred Formulary when prescribing brand-name drugs.

The Preferred Formulary has three tiers.

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

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

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

Tier Assignment Process

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

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

Other Provisions. All of the terms, conditions and limitations of the Contract, Certificate or Group Plan and Prescription Drug Rider to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



**EMPIRE HEALTHCHOICE HMO, INC.
RIDER REGARDING PRIOR AUTHORIZATION AND
SPECIALTY DRUG REQUIREMENTS
FOR PRESCRIPTION DRUGS**

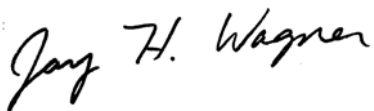
This rider changes benefits under your Prescription Drug rider as described more specifically below:

The prior authorization requirements described below apply to the prescription drug benefit described in the Prescription Drug Rider to your Contract, Certificate or Group Plan. This Rider is considered to be attached to, and a part of, the Rider.

1. **FDA-Approved Prescription Drugs.** The Prescription Drugs (or the prescribed quantity of a particular drug) listed on Schedule A.1 to this Rider require prior authorization. The Schedule is subject to periodic review and amendment. You may review a list of the current drugs requiring prior authorization by calling Customer Service at the telephone number on the back of your ID card or by going to our website at www.empireblue.com and clicking on "Drug Coverage" and "Formulary". Your provider or network pharmacist may also check with us at any time to verify coverage, any quantity limits, Step Therapy, and prior authorization requirements for prescription drugs. Please bear in mind that inclusion of a drug or related item on the Schedules to this Rider is not a guarantee of coverage under your Contract, Certificate or Group Plan. Refer to your Prescription Drug Rider for further information on drug coverage, limitations and exclusions.
2. **Step Therapy Program.** Step therapy means that a Covered Person may need to use one type of medication, such as a generic drug or a cost-effective alternative to a prescribed drug, before another. The Prescription Drugs listed on Schedule A.2 require prior authorization if a generic drug or cost-effective alternative Prescription Drug has not been tried.
3. Additional prescription drugs or categories of drugs may require prior authorization pursuant to the terms of your Prescription Drug Rider or your Contract, Certificate or Group Plan.
4. If you receive a prescription for a drug that requires prior authorization, your pharmacist will contact Empire to request approval.
5. If prior authorization is denied, you have the right to appeal through the appeals process outlined in your Contract, Certificate or Group Plan.

6. **Specialty Drugs.** You or your Physician are required to order your Specialty Drugs directly from a Network Specialty Pharmacy. “Specialty Drugs” are prescription drugs which:
- Are approved to treat limited patient populations, indications or conditions;
 - Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
 - Have limited availability, special dispensing and delivery requirements, and/or require additional patient support any or all of which make the drug difficult to obtain through traditional pharmacies.
- a. Network Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, up to a thirty (30) day supply for retail and mail service, and subject to the applicable Deductible, Coinsurance or Copayment shown in the Schedule of Benefits.
- b. Network Specialty Pharmacies have dedicated patient care coordinators to help you obtain prior authorization, if applicable, manage your condition, and offer toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications.
- c. You may obtain a list of the Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on the back of your ID card, or review the lists on our website at www.empireblue.com, select “Pharmacy” under the “Plans and Benefits” tab of the “Member Home” page.
- d. In addition, certain drugs that must be administered by a physician or other authorized practitioner are required to be ordered from our Network Specialty Pharmacy in order to be covered as a medical benefit. If you require one of these drugs, your physician or other treating practitioner will order the drug from the required pharmacy. You will not be required to fill a prescription for this category of drug.
7. Please refer to the Prescription Drug benefit sections of your Contract, Certificate or Group Plan for additional information on prescription drug coverage, limitations, and exclusions.

All of the terms, conditions and limitations of your Prescription Drug Rider and the Contract, Certificate or Group Plan under which it has been issued, also apply to this Rider, except where specifically changed by this rider.



JAY H. WAGNER
CORPORATE SECRETARY



MARK WAGAR
PRESIDENT

SCHEDULE A.1

Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Narcotic Analgesics	Actiq (fentanyl)
Antihypertensive	Adcirca
Antineoplastic	Afinitor
Antipsoriatics	Amevive
Androgens	Androderm
Androgens	Androgel
Colony Stimulating Factor	Aranesp
Antineoplastic	Avastin
Neuromuscular Blocker	Botox
Immune Globulin	Carimune NF
Enzyme	Ceredase
Enzyme	Cerezyme
Tumor Necrosis Factor Inhibitor – Crohn’s Disease	Cimzia
Gonadotropin-Releasing Hormone Analogs	Eligard
Tumor Necrosis Factor Inhibitor	Enbrel
Colony Stimulating Factor	Epogen
Antineoplastic	Erbix
Narcotic Analgesics	Fentora
Immune Globulin	Flebogamma
Antihypertensive	Flolan
Osteoporosis Agents	Forteo
Immune Globulin	GamaSTAN
Immune Globulin	Gammagard S/D
Immune Globulin	Gammagard liquid
Immune Globulin	Gamunex
Antineoplastics	Gleevac
Antineoplastic	Herceptin
Antirheumatic Agents	Humira
Growth Hormone	Increlex
Interferon	Infergen
Interferon	Intron-A
Antirheumatic Agents	Kineret
Antifungals	Lamisil
Colony Stimulating Factor	Leukine
Gonadotropin-Releasing Hormone Analogs	Leuprolide
Vascular Endothelial Growth Factor Inhibitor	Lucentis

Drug Class	Prescription Drug
Gonadotropin-Releasing Hormone Analogs	Lupron Depot products
Analgesics	Lyrica
Vascular Endothelial Growth Factor Inhibitor	Macugen
Neuromuscular Blocker	Myobloc
Colony Stimulating Factor	Neulasta
Myeloid Stimulant	Neumega
Colony Stimulating Factor	Neupogen
Antineoplastics	Nexavar
CNS Stimulant	Nuvigil
Immune Globulin	Octagam
Antirheumatic	Orencia
Immune Globulin	Panglobulin
Interferon	Pegasys
Interferon	Peg-Intron
Antifungal	Penlac
Immune Globulin	Polygam S/D
Immune Globulin	Privigen
Colony Stimulating Factor	Procrit
CNS Stimulant	Provigil
Antimalarials	Quaquin
Antirheumatic Agents	Remicade
Antihypertensive	Remodulin
Antihypertensive	Revatio
Immunomodulator	Revlimid
Antineoplastic	Rituxan
Agents for Hepatitis C	Roferon-A
Antidepressant	Savella
Tumor Necrosis Factor Inhibitor	Simponi
Antifungals	Sporanox
Antineoplastics	Sprycel
Gonadotropin-Releasing Hormone Analogs	Suprelin LA
Antineoplastics	Sutent
Gonadotropin-Releasing Hormone Analogs	Synarel Nasal Spray
Antineoplastics	Tarceva
Antineoplastics	Targetin (oral only)
Antineoplastics	Tasigna
Androgens	Testim
Immunomodulator	Thalomid
Anticonvulsants	Topamax

Drug Class	Prescription Drug
Gonadotropin-Releasing Hormone Analogs	Trelstar Depot
Gonadotropin-Releasing Hormone Analogs	Trelstar LA
Antineoplastics	Tykerb
Agents for Multiple Sclerosis	Tysabri
Gonadotropin-Releasing Hormone Analogs	Vantas Implant
Antineoplastic	Vectibix
Antihypertensive	Ventavis
Antifungals	Vfend
Immune Globulin	Vivaglobin
Opiod Antagonist	Vivitrol
Antineoplastics	Xeloda
Central Monoamine-Depleting Agent	Xenazine
Monoclonal Antibody	Xolair
Enzyme Inhibitor	Zavesca
Gonadotropin-Releasing Hormone Analogs	Zoladex
Antineoplastics	Zolinza
Antibiotic	Zyvox

SCHEDULE A.2

Step Therapy Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Antiacne-topical	Acanya
Proton Pump Inhibitor	Aciphex
Antihyperlipidemic	Advicor
Non-Sedating Antihistamine	Allegra ODT
Non-Sedating Antihistamine	Allegra suspension
Antiallergy-opthalmic	Alomide
Sedative/Hypnotics	Ambien CR
CNS Stimulant	Amphetamine Salt Combo
Non-Steroidal Antiinflammatories	Arthrotec
Nasal Steroids	Beconase AQ
Antiacne-topical	Benzaclin
Hypoglycemics	Byetta
Non-Steroidal Antiinflammatories	Celebrex
Non-Sedating Antihistamine	Clarinet-D
Non-Sedating Antihistamine	Clarinet suspension
Antiallergy-opthalmic	Elistat
Dermatological Agent	Elidel
Antiallergy-opthalmic	Emadine
Nasal Steroids	Flunisolide Nasal Spray
Antihyperlipidemic	Lescol
Antihypertensive	Letairis
Nasal Steroids	Nasacort AQ
Nasal Steroids	Nasarel
Nasal Steroids	Omnaris
Proton Pump Inhibitors	Omeprazole 40mg
Antiallergy-opthalmic	Optivar
Antiallergy-opthalmic	Pataday
Antiallergy-opthalmic	Patanol
Proton Pump Inhibitors	Prilosec
Dermatological Agent	Protopic
Nasal Steroids	Rhinocort Aqua
Sedative/Hypnotics	Rozorem
Sedative/Hypnotics	Sonata
Nasal Steroids	Veramyst
Antihyperlipidemics	Vytorin

Drug Class	Prescription Drug
Proton Pump Inhibitors	Zegerid
Antihyperlipidemics	Zetia



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE WOMEN'S HEALTH AND CANCER RIGHTS ACT

This Rider amends the HMO Contract or Certificate as follows:

1. The Hospital and Physician Network Rider to your Certificate, if any, is hereby deleted in its entirety.
2. The definition of "Select Network," if any, and any references to "Select," or "Select Network," are hereby deleted from your Certificate.
3. The definition of "Prestige Network," if any, and any references to "Prestige," or "Prestige Network," are hereby deleted from your Certificate.
4. The definition of "Participating Provider," is hereby deleted and replaced with the following:

Participating Provider means any professional provider, or a hospital, skilled nursing or other Facility, home health agency, laboratory, or other person or entity which has an agreement to provide covered services to HMO members and participates in a network that was chosen by your group, or by you if your group allows you to make the choice, to provide services to you and your covered family members. We will not pay for health services from a non-participating provider except: in an emergency; when, in our sole judgment, the care you require is not available from a Participating Provider and we preauthorize the services of the non-participating provider; when you receive urgent care while traveling or visiting outside our Service Area; or you receive benefits under the Guest Membership program.

Other Conditions. All of the terms, conditions and limitations of your HMO Certificate to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

Handwritten signature of Jay H. Wagner in black ink.

Jay H. Wagner
Corporate Secretary

Handwritten signature of Mark Wagar in black ink.

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE WOMEN'S HEALTH AND CANCER RIGHTS ACT

This rider increases the coverage under your HMO Contract or Certificate.

1. Services Covered Following Mastectomies. In addition to the benefits provided under your HMO coverage for breast reconstructive surgery, we will provide coverage for the following services in connection with a mastectomy:

- Hospital care for breast reconstruction surgery.
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

The coverage described above will be provided in a manner determined in consultation with the attending physician and the patient.

Other Provisions. All of the terms, conditions, and limitations of the Contract or Certificate to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT REGARDING SPECIAL ENROLLMENT PERIODS

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below. If a provision to this Rider conflicts with a provision in your Contract, Certificate or Group Plan, the provisions in this Rider control.

A. Section 2, "Who Is Covered," bullet 7. is replaced in its entirety as follows:

7. When You Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage.

An eligible Member, or dependent of a Member, who rejects initial enrollment under this Certificate may enroll for coverage under this Certificate if the following special enrollment conditions are met:

A. The Member or dependent was covered under another plan or contract when coverage under this Certificate was initially offered, and

i. Coverage was provided in accordance with continuation required by state or federal law and was exhausted; or

ii. Coverage under the other plan or contract was terminated as a result of loss of eligibility for one or more of the following reasons:

- termination of employment,
- termination of the other plan or contract,
- death of the spouse,
- legal separation, divorce or annulment,
- reduction in the number of hours worked,
- an employer no longer offering benefits to a class of individuals such as part time workers,
- lifetime maximum being met under such insurance; or

iii. The employer or other group ceased its contribution toward the payment of premium for the other plan or contract.

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

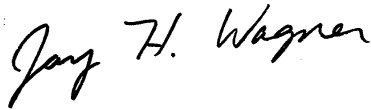
C. Coverage must be applied for under this Certificate within thirty (30) days for one of the qualifying special enrollment events described in this section.

D. Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program).

The Employee or Dependent must request Special Enrollment within sixty 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached, including any applicable pre-existing condition limitations, also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

EXTERNAL APPEAL PROCESS FOR EXPERIMENTAL/INVESTIGATIONAL DENIALS FOR THE TREATMENT OF RARE DISEASES

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below.

The section of your Contract, Certificate or Group Plan that describes your External Appeal rights when benefits are denied or reduced based on a Medical Management Program decision, is amended to add the following:

External Appeals for Determinations Involving Experimental or Investigational Treatment for Rare Diseases

1. In order to request an external appeal under the provisions of this Rider, your attending physician must certify that you have a rare disease. "Rare disease" means a life threatening or disabling condition or disease that:
 - a. (i) Is currently or has been subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network; or (ii) affects fewer than 200,000 United States residents per year; and
 - b. For which there does not exist a covered standard health service or procedure that is more clinically beneficial than the requested service or treatment.
2. The rare disease external appeal may be filed by you or your designee. For retrospective and concurrent adverse determinations, it may be filed by your health care provider.
3. Your attending physician must have recommended the health service or procedure (including a pharmaceutical product) based on an independent physician's certification that (i) it is likely to benefit you in the treatment of the rare disease, and (ii) the benefit to you outweighs the risks of the service or procedure.

Your attending physician must submit a statement of the evidence that he or she relied on in certifying the recommendation.

4. The external appeal application must also include the certification of a board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the rare disease, and who is not your treating physician.

The certification must state that:

- a. the disease or condition constitutes a "rare disease" as defined above; and
- b. the Covered Person's rare disease is currently, or has been subject to, a research study by the National Institutes of Health Rare Diseases Clinical Research Network, or that it affects fewer than 200,000 United States residents per year.

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In addition, the certification must also:

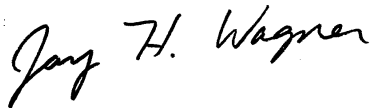
- c. Rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists; and
- d. Include a statement that:
 - (i) Based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial than the requested health service or procedure; and
 - (ii) The proposed treatment is likely to benefit the Covered Person and the benefits outweigh the treatment risks.

The independent, certifying physician must disclose any material financial or professional relationship with the provider of the requested service or procedure in the external appeal application.

If the requested health service or procedure at a health care facility requires prior approval of an institutional review board, such approval must be included as part of the external appeal application.

- 5. If a majority of the panel of external reviewers determines that the requested health service or procedure is likely to benefit the Covered Person in the treatment of the rare disease and that the benefit outweighs the risks of the service or procedure; or if the reviewing panel is evenly divided as to a determination concerning the appeal, Empire will be required to cover the proposed service or procedure.
- 6. The external appeal agent will make a determination within thirty (30) days of receipt of your request, unless the attending physician states that a delay will cause an imminent or serious threat, in which case the external appeal will be completed within three (3) days.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached, including any applicable pre-existing condition limitations, also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

REGARDING EXTENSION OF CONTINUED COVERAGE AFTER LOSING ELIGIBILITY

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below. This Rider includes mandated provisions to New York State Continuation of Coverage Rights. If a provision to this Rider conflicts with a provision in your Contract, Certificate or Group Plan, the provisions in this Rider control.

The provisions of your Contract, Certificate or Group Plan relating to when a Covered Person may continue group coverage after losing eligibility in the group under federal and New York State law are hereby deleted and replaced with the following:

When a Covered Person May Continue Group Coverage After Losing Eligibility in the Group.

Under certain circumstances, described below, Covered Persons who would otherwise lose coverage under the eligibility provision of their group plan may retain group coverage as "Continued Coverage Beneficiaries" for limited periods of time noted below.

1. Period of Continued Coverage Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

Periods of coverage vary depending on the reasons why eligibility under this Certificate or Certificate was lost. Under COBRA, continued coverage is generally available for up to eighteen (18) or thirty-six (36) months.

- a. When a Covered Person's employment terminates for any reason, other than gross misconduct, or the number of hours he works is reduced so that he is no longer eligible for group coverage, continued coverage under COBRA is available for up to eighteen (18) months. (This may not apply to certain nonresident aliens with United States source-earned income of up to three thousand dollars (\$3,000)).
- b. Such eighteen (18) month period of coverage may be extended for up to an additional eleven (11) months for a total of twenty-nine (29) months if the Covered Person is determined to be disabled under the Social Security Act at the time of termination of employment or reduction of hours or at any time during the first 60 days of continuation of coverage. Such Covered Person must provide notice to the Group Health Plan Administrator before the end of the initial eighteen (18) months and within sixty (60) days of such disability determination. If the Covered Person is determined to be no longer disabled under the Social Security Act, such Covered Person must provide notice to the Group Health Plan Administrator within thirty (30) days of such determination.
- c. When a Covered Person is no longer eligible for group coverage under this Certificate because (i) he no longer qualifies for coverage under the definition of "Children," (ii) the Member dies, (iii) the Member is divorced or legally separated from his spouse, or (iv) the Member becomes entitled to Medicare, continued coverage is available for the dependents under COBRA for up to thirty-six (36) months.

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- d. If a Continued Coverage Beneficiary experiences one of the events listed in paragraph (c) above during his eighteen (18) month period of continued coverage, he may receive an additional eighteen (18) months of continued coverage for a maximum of thirty-six (36) months of continued coverage. Such additional coverage is measured from the date of the event for which he first became entitled to continued coverage, as set forth in paragraph (a) above. Under certain circumstances, a Continued Coverage Beneficiary is entitled to thirty-six (36) months of continued coverage as measured from the date of Medicare entitlement. This could result in a total of more than thirty-six (36) months of continued coverage.
- e. Continued coverage may be available under this Certificate because the Member who is a retiree loses coverage due to the Group's commencement of proceedings under Title 11 of the Federal Bankruptcy law. Continuation Coverage for such retirees and their surviving spouses can be lifetime, and can extend up to thirty-six (36) months after the death of the retiree for the surviving spouse and dependent children. Termination of continued coverage may be subject to special requirements.

2. Notification Requirements Under COBRA

- a. The Covered Person must notify the Group within sixty (60) days after (i) a divorce or legal separation, (ii) the date he or a family member no longer qualifies for coverage under the definition of "Children" in the Certificate, or (iii) the date coverage would otherwise end due to such an event, whichever is the latest.
- b. The Group must separately notify each Continued Coverage Beneficiary of his right to continue coverage in accordance with COBRA within fourteen (14) days after learning of a qualifying event.

3. Election of Continued Coverage

Under COBRA, if a Covered Person would like continued coverage, he must advise the Group of his decision to continue coverage in writing within sixty (60) days after the date he is notified of his right to continue coverage, or the date his coverage would otherwise end, whichever is later.

4. Payment of Premiums

- a. Under COBRA, Continued Coverage beneficiaries have the right to pay premiums not more than once a month.
- b. Under COBRA, the amount of premiums may not exceed one hundred and two percent (102%) of the actual cost of coverage provided under this Certificate. However, if coverage is extended under COBRA due to a disability determination, the amount of premiums may not exceed one hundred and fifty percent (150%) of the actual cost of the coverage provided under this Certificate from the nineteenth (19th) through the twenty-ninth (29th) month of continuation coverage. The first payment for premiums is due forty-five (45) days from the date the Covered Person elects to continue coverage.

5. Termination of Continued Coverage

- a. Under COBRA, continued coverage generally ends at the earliest of the following:
 - (i) when the Continued Coverage Beneficiary becomes covered under another group Contract, unless such other group Contract affecting the Continued Coverage Beneficiary has any exclusion or limitation with respect to any preexisting condition, in which case continued coverage ends at the earliest of: a) when the pre-existing limitation period of

- the other group Contract has expired, or b) the applicable eighteenth (18th), twenty-ninth (29th) or thirty-sixth (36th) month of coverage has expired, or
- (ii) eighteen (18) months after the date of one of the events described in paragraph 1 (a), or
- (iii) twenty-nine (29) months after the date of one of the events described in paragraph 1 (a), unless sooner terminated because the Continued Coverage Beneficiary is determined to be no longer disabled under the Social Security Act, or
- (iv) thirty-six (36) months after the date of one of the events described in paragraph 1 (c) or 1 (d).

b. Under COBRA, continued coverage ends when any of the following events occurs:

- (i) The Continued Coverage Beneficiary fails to pay the premiums when due.
- (ii) The Group no longer provides group health insurance to any of its employees or members.
- (iii) The Continued Coverage Beneficiary becomes entitled to Medicare.

6. The Right to Elect Additional Continued Coverage Under New York State Law When Continued Coverage Under Federal Law Ends

Covered Persons who have exhausted continued coverage available under COBRA may purchase additional continued coverage as permitted by the New York State Insurance Law up to a total of thirty-six (36) months from the date continued coverage under federal COBRA began.

Note: This right to elect additional continued coverage does not apply to Covered Members who elect to continue coverage through age twenty-nine (29) under the New York Young Adult Mandatory Right of Election.

7. The Right to Convert Coverage When Continued Coverage Ends

When continued coverage ends, a Continued Coverage Beneficiary may convert his coverage according to the terms of the Article describing the termination and conversion provisions of this Certificate.

8. Continued Coverage Under Section 3221(m) of the New York State Insurance Law (New York State Law)

If the insurance of a Covered Person under the group policy ends because of termination of employment or of membership in the class or classes eligible for coverage under this Certificate, and the Covered Person is not entitled to temporary continuation of coverage under COBRA (for example because the employer has less than twenty (20) employees), the Covered Person may be entitled to continuation of coverage under the provisions of Section 3221(m) of the New York State insurance law, subject to the terms and conditions of this Certificate.

9. Notification Requirements Under New York State Law

- a. The Covered Person must notify the Group in writing within sixty (60) days after the date employment ends, or the date he is sent notice by first class mail of his right of continuation by the Group, whichever is later.
- b. If a Covered Person is disabled under Title II or Title XVI of the Social Security Act at the time employment ends or within the first sixty (60) days of continued coverage, he must notify the Group within sixty (60) days of the determination of disability under the Social Security Act.

10. Payment of Premiums for New York State Continued Coverage

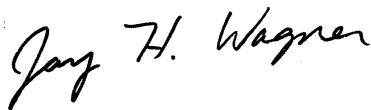
- a. Covered Persons who elect continued coverage have the right to pay premiums not more than once a month.
- b. The amount of premiums may not exceed one hundred and two percent (102%) of the actual cost of coverage provided under this Certificate. The first premium payment is due sixty (60) days from the date benefits would otherwise have terminated.

11. Termination of New York State Continued Coverage

Continuation of benefits under the group policy will terminate on the earliest to occur of the following:

- a. Thirty-six (36) months after the Covered Person's benefits under the policy would otherwise have ended because of termination of employment or membership in an eligible class; or
- b. The end of the period for which premium payments were made, if the Covered Person fails to pay the premium when due; or
- c. In the case of an eligible dependent of a Covered Person, thirty six (36) months after the date the dependent's benefits under the policy would otherwise have terminated by reason of:
 - (i) the death of the Covered Person;
 - (ii) the divorce or legal separation of the Covered Person from his or her spouse;
 - (iii) the Covered Person becoming entitled to benefits under Title XVIII of the Social Security Act; or
 - (iv) a dependent child ceasing to be a dependent child under the terms of this Certificate.
- d. The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this clause applies and the coverage is replaced by similar coverage under another group policy:
 - (i) The Covered Person has the right to be covered under the other group policy for the rest of the period that he would have remained covered under the prior group policy, and
 - (ii) The minimum level of benefits to be provided by the other group policy will apply to the Covered Person but will be reduced by any benefits payable under the prior group policy, and
 - (iii) The prior group policy will provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred; or
- e. The date on which the Covered Person becomes covered by any other arrangement that provides hospital, surgical or medical coverage for individuals in a group and does not contain any limitation with respect to a pre-existing condition of the Covered Person.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached, including any applicable pre-existing condition limitations, also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

CONTINUATION OF COVERAGE RIGHTS FOR DEPENDENTS THROUGH AGE 29

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below.

Your Contract, Certificate or Group Plan is hereby amended to add the following:

A. Covered members may purchase extended coverage for their young adult dependents once the dependent reaches the maximum dependent age set forth on your Schedule of Benefits (Maximum Dependent Age). Such extended coverage will be available through age 29, subject to the terms and conditions of the Contract, Certificate or Group Plan and this Rider. The coverage provided will be identical to the coverage provided to the covered member and will be issued through a separate policy. Coverage is not available under this Rider for any dependents, including children, of the eligible Dependent.

B. Eligible Criteria

To be eligible for extended coverage under this Rider, the dependent must:

1. be the unmarried dependent of a covered member;
2. be under age 30;
3. not be insured by, or eligible for coverage through the dependent's own employer-sponsored group policy, whether insured or self-insured;
4. live, work or reside in New York State; and
5. not be covered by Medicare.

The dependent must also meet the other eligibility requirements set forth in the Contract, Certificate or Group Plan.

C. Extended dependent coverage may be purchased under this Rider at the following times:

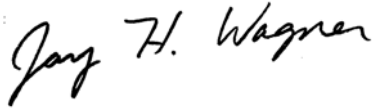
- within 60 days of the date the dependent reaches the Maximum Dependent Age;
- within 60 days of becoming eligible if the dependent previously reached the Maximum Dependent Age; or
- during an annual 30 day open enrollment period which shall be extended by the employer or group policyholder for this purpose.

- D. The election must be in writing, be accompanied by the first premium payment and given to the group policyholder or employer.

The continued coverage will terminate on the first of the following to occur:

- the date the dependent no longer meets eligibility requirements as stated in section (B) above;
- the date the parent of the covered dependent ceases to be eligible for coverage under the Contract, Certificate or Group Plan to which this Rider is attached;
- the last day to which premium is paid if there is default; or
- the date the group policy is terminated.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice HMO, Inc. to which it is attached as described below.

1. **SECTION TWO, 1. "Who Is Covered," A.**, is hereby deleted in its entirety and replaced with the following:

Your Spouse – an opposite sex or same-sex spouse to a marriage that is legally recognized in the jurisdiction (State or Country) in which it is performed. Former spouses, as a result of a divorce or annulment of a marriage, are not considered eligible spouses.

2. **SECTION TWO, 7. "When You Reject Initial Enrollment, But Do Not Need to Wait Until the Group's Open Enrollment Period to Enroll for Coverage,"** is hereby amended by adding the following:

D. Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

3. **SECTION NINE, "EXCLUSIONS," 16.**, is hereby deleted in its entirety and replaced with the following:

We will not pay for any service, treatment or procedure in connection with any of the following:

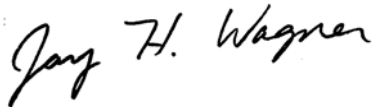
- Required for a condition arising out of war or act of war, whether declared or undeclared.
- Surgery for treatment of obesity for purposes of weight reduction, including gastric stapling, gastric by-pass, gastric bubble and any other surgery we determine to be medically inappropriate for treatment of obesity.
- Weight loss counseling, except when provided by your PCP.

4. **SECTION NINE, "EXCLUSIONS," 18., "Benefits for Medicare Eligibles Who Are Covered Under This Certificate,"** is hereby deleted in its entirety and replaced with the following:

A. If your group has twenty (20) or more employees, any active employee or spouse of an active employee who becomes or remains a member of the Group covered by this Certificate after becoming eligible for Medicare due to reaching age sixty-five (65), will receive the benefits of this Certificate as primary. The Group must notify us of the Covered Person's election and pay the appropriate premiums. If such Covered Person elects Medicare as primary, such Covered Person shall not be eligible for coverage under this Certificate as of the date of such election.

- B. If your Group has one hundred (100) or more employees or your Group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or dependent child of an active employee who becomes or remains a member of your Group covered by this Certificate after becoming eligible for Medicare due to disability will receive the benefits of this Certificate as primary. The Group must notify us of the Covered Person's election and pay the appropriate premiums. If such Covered Person elects Medicare as primary, such Covered Person shall not be eligible for coverage under this Certificate as of the date of such election.
- C. If you have end stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective, your coverage under this Certificate will be primary during the waiting period. It will also be primary during the coordination period with Medicare. After the coordination period, Medicare is primary.
- D. If you are a retiree or an active employee or spouse of an active employee who is not subject to Paragraphs A or B above and who is Medicare eligible you will continue to receive the benefits of the Certificate, however, your Medicare coverage will become primary. In order to ensure full coverage, you must enroll in Medicare, sign any claim forms or other documents which are necessary for us to obtain payments from Medicare for services provided to you through the HMO. If you do not enroll or do not sign the forms or other documents and submit them to us, we have the right to deny HMO payments for the service.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

LOCAL NETWORK AREA RIDER

This Rider amends your Contract or Certificate of Coverage to extend the area within which you may obtain in-network services.

1. **Definition of Local Network Area.** In Section One, Paragraph 4, pertaining to "Definitions," a new definition is added to read as follows:

"Local Network Area" means the 28 counties in eastern New York State that comprise the Service Area, and the following Connecticut counties, which are located in the service area of Empire's affiliate, Anthem Blue Cross and Blue Shield, Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham.
2. **Persons Not Covered.** In Section Two, Paragraph 5, pertaining to "Persons Not Covered," the term "Service Area" wherever it appears, is replaced by the term "Local Network Area".
3. **Exclusions.** In Section Nine, Paragraph 3, pertaining to "Care Provided Outside of the HMO Service Area," the terms "HMO Service Area" and "28 county HMO Service Area", wherever they appear, are replaced by the term "Local Network Area".
4. **Other Provisions.** All of the terms, conditions and limitations of your EMPIRE HEALTHCHOICE HMO, INC. Contract or Certificate to which this Rider is attached remain in full force and effect, except where specifically changed by this Rider.
5. **New Contract After Termination Of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract or Certificate ends may not include any of the benefits of this Rider.

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

OUTPATIENT BEHAVIORAL HEALTH CARE SERVICES PRECERTIFICATION RIDER

This rider changes benefits under your Contract, Certificate or Group Plan as described more specifically below regarding the process for precertification (authorization) of outpatient behavioral health care services, which includes mental health care and substance abuse services.

- A. The process for authorization of behavioral health care services will change from requiring precertification prior to the initial visits to requiring authorization, including the clinical review and medical necessity determination, after an initial 12 visits are exhausted. Upon the thirteenth visit, an outpatient treatment report will be required, and a licensed care manager will review and determine the medical necessity and continued authorization. These first 12 visits will apply per provider, per calendar year. An outpatient treatment report, review and authorization will always be required prior to the thirteenth visit.
- B. Outpatient services are defined as services provided by an independently billing, licensed health care specialist acting within the scope of his or her license and/or a licensed mental health care or substance abuse facility, hospital or agency. Place of service includes office based, facility, or rural health centers. Type of service includes those services requested via an outpatient treatment report.
- C. Overnight in a hospital (including observation only); partial hospital programs; psychological testing; and intensive outpatient programs are excluded from outpatient services and will continue to require prior authorization prior to the initial visit. Medication management and diagnostic evaluations do not require prior authorization

All of the terms, conditions, and limitations of the Contract, Certificate, or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.

A handwritten signature in cursive script that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in cursive script that reads "Mark Wagar".

Mark Wagar
President

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans.



EMPIRE HEALTHCHOICE HMO, INC.
(the "Company")

**RIDER TO YOUR CONTRACT OR CERTIFICATE
REGARDING ENROLLING A NEWBORN CHILD**

This rider amends the requirements for enrolling a newborn child under your Contract, Certificate, or Group Plan as described below.

- A. For a Member who has individual (for self only), employee\spouse, or parent\child (two-person) coverage:
1. He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
 2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
 3. If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form, provided that it is during the next open enrollment period after the birth or within the first year after the birth, whichever occurs first.
 4. If you do not switch to a parent\child, parent\children, or family contract and enroll your newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Contract, Certificate or Group Plan, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery.
- B. For a Member who has family or parent\children (more than two person) coverage:
1. A newborn child, or a proposed adopted newborn, will be covered from the date of birth.
 2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.
 3. Coverage will still be effective from the date of birth for a newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
 4. Any claims for a newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery .

All of the terms, conditions, and limitations of the Contract, Certificate, or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.

Handwritten signature of Jay H. Wagner in black ink.

Jay H. Wagner
Corporate Secretary

Handwritten signature of Mark Wagar in black ink.

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER FOR INFERTILITY TREATMENT SERVICES

This rider adds benefits for Medically Necessary services for the diagnosis and treatment of infertility to your Contract, Certificate or Group Plan as described below. All of the terms, conditions and limitations of the Contract or Certificate to which this Rider is attached, also apply to this Rider, except where they are specifically changed by this Rider.

1. **Infertility Defined.** For the purposes of this Rider, infertility has the meaning set forth in regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, as further defined in regulations.
2. **Covered Services.** Subject to the other provisions of this Rider and your Contract, Certificate or Group Plan, we will provide benefits under this Rider for:
 - A. Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility ; and
 - B. Services in relation to diagnostic tests and procedures necessary:
 1. to determine infertility; or
 2. in connection with any surgical or medical procedures to diagnose or treat infertility.

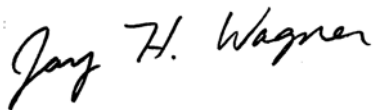
The diagnostic tests and procedures covered by this Rider are:

 - hysterosalpingogram;
 - hysteroscopy;
 - endometrial biopsy;
 - laparoscopy;
 - sono-hysterogram;
 - post-coital tests;
 - testis biopsy;
 - semen analysis;
 - blood tests;
 - ultrasound; and
 - other Medically Necessary diagnostic tests and procedures, unless excluded by law; and
 - C. If the Contract, Certificate or Group Plan to which this Rider is attached covers prescription drugs, it will also include, prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services. This prescription drug benefit is subject to the same conditions, exclusions, limitations and requirements that apply to all other prescription drugs under your Contract, Certificate or Group Plan, except as specifically modified by this Rider.

In addition to the mandated benefits described in paragraphs A., B. and C. above, the Contract, Certificate or Group Plan to which this Rider is attached will provide coverage for hospital, surgical and medical care for the diagnosis and treatment of correctable medical conditions that are otherwise covered by the policy without regard to whether the medical condition or the treatment for the condition may result in infertility.

3. **Deductibles, Copayments and Coinsurance.** The benefits of this Rider are subject to any applicable deductible, copayment, or coinsurance provisions of your Contract, Certificate or Group Plan that apply to the services or treatment rendered.
4. **Services Must Be Medically Necessary.** We will not provide benefits for a service to diagnose or treat infertility if we determine, in our sole judgment, that the service was not “medically necessary,” as that term is defined in your Contract or Certificate.
5. **Excluded Services.** We will not pay benefits for any services related to or in connection with:
 - In-Vitro Fertilization;
 - Gamete Intra-Fallopian Transfer (GIFT);
 - Zygote Intra-Fallopian Transfer (ZIFT);
 - Reversal of elective sterilizations, including vasectomies and tubal ligations;
 - Sex change procedures;
 - Cloning;
 - Other procedures or categories of procedures excluded by statute.
6. **Experimental Procedures Not Covered.** This Rider does not cover services or procedures that we, in our sole judgment, determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in the External Appeal provision of your Contract or Certificate.
7. **New Contract After Termination of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Plan ends may not include any of these infertility benefits provided by this Rider.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

This Rider changes coverage under your HMO Contract or Certificate and adds the following provisions:

1. Coverage of a full-time student who takes a medical leave of absence from school due to illness or injury will continue until the earlier of: the date twelve (12) months after the last day of attendance at school; or the date upon which coverage as a full-time student would otherwise terminate under this Certificate.
2. Benefits for Standard Diagnostic Testing including but not limited to Prostate Specific Antigen (PSA) and digital rectal examination when prescribed by a health care provider legally authorized to prescribe are available:
 - a. For men at any age having a prior history of prostate cancer;
 - b. Annually for men age fifty (50) and over who are asymptomatic, and
 - c. annually for men with a family history of prostate cancer or other prostate cancer risk factors who are age forty (40) and over.

3. The following provision is added to the Ambulance Service benefit in your Contract or Certificate:

Prehospital Emergency Services and Transportation. We will provide coverage for services to evaluate and treat an “emergency condition,” as that term is defined in this certificate when such services are provided by an ambulance service certified under the Public Health Law. We will also provide coverage for land ambulance transportation to a hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, place the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

4. **Access to End of Life Care.** Any Covered Person who is diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty (60) days to live, as certified by the patient’s attending health care practitioner) is entitled to coverage for acute care services at an acute care facility licensed pursuant to article twenty eight of the Public Health Law, specializing in the treatment of terminally ill patients, if the patient’s attending health care practitioner, in consultation with the medical director of the facility, determines that the Covered Person’s care would appropriately be provided by the facility.

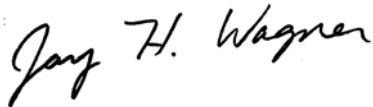
If Empire disagrees with the admission of or provision or continuation of care for the Covered Person by the facility, it shall have the right to initiate an expedited external appeal in accordance with the Public Health Law 4914 (2) (c), except that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by Empire and Empire shall provide coverage and reimburse the facility for services provided subject to the limitations otherwise applicable under the Covered Person’s contract, including the applicable cost sharing requirements. The decision of the external appeal agent shall be binding on all parties.

Services provided by Empire HealthChoice HMO Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

5. This rider deletes the subsection in the EXCLUSIONS section of your Contract or Certificate entitled "Dental Care" and replaces it with the following:

Dental Care. Treatments for cavities and extractions, care of the gums or bones supporting the teeth, treatment for periodontal abscess, orthodontia, and false teeth, treatment for temporomandibular joint (TMJ) syndrome or orthognathic surgery which are dental in nature, are all excluded, as are any other dental services received. However, we will cover medically necessary surgical excision of an impacted tooth and services necessary due to an accidental injury to sound natural teeth rendered within 12 months of the accident, and dental care or treatment necessary due to congenital disease or anomaly.

Other than as stated above, there are no other changes to any of the terms, limitations or exclusions of the Contract or Certificate to which this rider is attached.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

This rider changes coverage under the Empire HealthChoice HMO, Inc. Contract or Certificate to which it is attached and adds the following:

Subrogation

1. 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.
2. 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.
3. 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.

Other Provisions. All of the terms, conditions and limitations of your Empire HealthChoice HMO, Inc. Contract or Certificate to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

This rider amends the Contract or Certificate to which it is attached and adds the following benefit:

1. Benefits are available for bone mineral density measurements or tests. This includes measurements and tests which are covered under the standards and criteria of the federal Medicare program and the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

These benefits are available for individuals that Empire determines meet the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum, include individuals:

- a. previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
 - b. with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
 - c. on a prescribed drug regimen posing a significant risk of osteoporosis; or
 - d. with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
 - e. with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.
2. For Direct Payment Contracts and for Group Contracts which have prescription drug riders purchased by the Group, benefits will also include prescription drugs and devices or generic equivalents, approved by the federal food and drug administration, subject to all of the above requirements.

Other than as stated above, there are no other changes to any of the terms, limitations or exclusions of the Contract or Certificate to which this rider is attached.

A handwritten signature in cursive script that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in cursive script that reads "Mark Wagar".

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

This rider amends the Contract or Certificate to which it is attached as follows:

1. The Mammography Screening Benefit is increased as follows:

Benefits are available at any age for Covered Persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. This includes a Covered Person's mother, sister or child.

An annual mammogram is available for covered persons aged 40 and older.

2. There are no other changes to the Mammography Screening benefit.

Other than as stated above, there are no other changes to any of the terms, limitations or exclusions of the Contract or Certificate to which this rider is attached.

A handwritten signature in black ink that reads "Jay H. Wagner".

Jay H. Wagner
Corporate Secretary

A handwritten signature in black ink that reads "Mark Wagar".

Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR HMO CONTRACT Out-of-Network Dialysis Services

This Rider changes provisions in, or adds provisions to, your HMO Contract issued by Empire HealthChoice HMO, Inc., including any affected riders, endorsements or other amendments thereto (hereinafter collectively referred to as "Your Contract") issued by "Us. Except as otherwise provided in this Rider, the provisions herein apply to all persons covered under Your Contract ("Members"). This Rider shall be effective on the later of January 01, 2011 or the initial effective date of Your Contract.

1. The first provision of "SECTION ONE — INTRODUCTION; DEFINITIONS; MEDICAL MANAGEMENT PROGRAM" called "Healthcare Through the HMO Concept," is expanded to provide that in limited circumstances, dialysis services provided by Non-Participating Providers are Covered Services, when rendered in accordance with the terms of this Rider.
2. The definition for "Participating Provider" under Paragraph 4 of "SECTION ONE — INTRODUCTION; DEFINITIONS; MEDICAL MANAGEMENT PROGRAM" is expanded to provide that we will pay for dialysis services provided by a Non-Participating Provider under the limited circumstances specified herein.
3. Paragraph 1.A. of "SECTION THREE — HOSPITAL CARE" pertaining to "Inpatient Care in a Hospital," is expanded to provide that we will pay for dialysis services rendered by a Non-Participating hospital when the dialysis services are required to be provided on an inpatient basis outside our Service Area under the limited circumstances specified herein.
4. The provision "Hemodialysis" is hereby added to the end of Paragraph 2 of "SECTION THREE — HOSPITAL CARE" as follows:

Hemodialysis. We will pay for dialysis treatment on a walk-in basis in a Participating Hospital or in a Participating Freestanding Dialysis Facility. We will pay for home treatment; this includes the rental cost of equipment, plus all medically necessary supplies. We will not pay for furniture, electrical or other fixtures or plumbing.

In addition, we will cover up to ten (10) dialysis treatments per year received from a Non-Participating Provider if the following conditions are met:

- The Non-Participating Provider is duly licensed to practice and authorized to provide dialysis treatment;
- The Non-Participating Provider is located outside our Service Area;
- You have a written order from the Participating Provider stating that the treatment is necessary; and
- You notified the Plan, in writing, including the written order from the Participating Provider, at least thirty days in advance of the proposed treatment date(s). If you need to travel on sudden notice due to an emergency, the thirty day notice may be shortened if the Plan has a reasonable opportunity to review your travel and treatment plans.

All terms of your Contract relating to utilization review and cost sharing for dialysis services rendered by a Participating Provider will apply to the out-of-area dialysis services.

We will reimburse the Non-Participating Provider for dialysis services provided pursuant to this Rider up to the amount payable by Us for such services when rendered by a Participating Provider. You will be responsible for any Copayment that applies to in-network dialysis services, including drugs and ancillary services tied to the dialysis treatment, plus any additional amount billed by the Non-Participating Provider up to the provider's full charges.

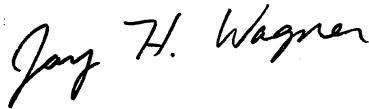
5. Paragraph 2 of "SECTION NINE — EXCLUSION" is deleted in its entirety and replaced with the following :

SECTION NINE — EXCLUSIONS

In addition to certain exclusions and limitations already described in this Contract, we will not pay under this Contract when any of the following apply to you:

2. Care by Non-Participating Providers. Except in an emergency, or under limited circumstances with dialysis services, we will not pay for care rendered by Non-Participating Providers.

Other Provisions. All of the terms, conditions, and limitations of Your Contract to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE REGARDING PRECERTIFICATION AND PRIOR AUTHORIZATION REQUIREMENTS

This rider changes benefits under your Contract, Certificate or Group Plan as described more specifically below by changing the coverage terms relating to your benefits and cost sharing obligations.

The Section entitled, "Introduction; Definitions; Medical Management Program," in the Contract or Certificate (Contract) to which this Rider is attached is amended as follows:

Subsection 5, "Medical Management Program," is deleted in its entirety and replaced with the following:

5. Medical Management Program. The Medical Management Program (MMP) is a program which must be complied with in order to receive the benefits available under this Certificate. MMP works with you and/or your Participating Provider to ensure that you receive medically appropriate health services at an appropriate level of medical care.

A. The following services must be preauthorized by MMP:

- All inpatient admissions, including admissions for illness or injury to newborns;
- Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification;
- Partial Hospital Programs, Psychological Testing, Intensive Outpatient Programs;
- Air ambulance;
- Outpatient/Ambulatory Surgical Treatments (certain procedures);
- Cardiac rehabilitation;
- Durable medical equipment and prosthetics;
- Home care and home infusion therapy;
- Hospice care;
- High tech radiology services: MRIs, MRAs, PET, CAT, CTA, MRS, CT/PET, SPECT, ECHO Cardiology, Nuclear Technology services;
- Occupational and physical therapy;
- Skilled nursing facility care;
- Speech therapy;
- Vision therapy;
- Outpatient treatments;
- Diagnostics.

B. MMP must be contacted by your attending Participating Physician, Home Health Agency, Durable Medical Equipment or Prosthetics Vendor, as appropriate, to request for pre-certification before services are rendered, or as follows:

- At least two weeks prior to the planned admission or surgery when your Participating Physician recommends inpatient hospitalization. If that is not possible, then during regular business hours any time prior to admission.

- Within forty-eight (48) hours after you are admitted to a hospital because of an Emergency or as soon as reasonably possible, including Medical, Behavioral Health, Substance Abuse and Alcohol Detoxification emergency admissions and Air Ambulance.

If, due to a Emergency Condition, medical emergency, the Covered Person is unable to notify MMP of a hospitalization within the required time period, the Covered Person must notify MMP of the emergency admission once he is medically able to do so.

“Emergency Condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

- Before Air Ambulance services are rendered, or within forty-eight (48) hours after admission to or treatment at a hospital, when needed to transport a Covered Person to the nearest acute care hospital in connection with an Emergency Condition, as outlined above, when the following conditions are met:
- A Covered Person’s medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances or other geographic obstacles, and the use of land transportation would pose an immediate threat to the Covered Person’s health.
- Services will be covered for an In-Network air ambulance used to transport a Covered Person from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for the Covered Person’s treatment as determined by Empire, and use of a land ambulance would pose an immediate threat to the Covered Person’s health.

If it is determined by Empire that the conditions for coverage for Air Ambulance services have not been met but the Covered Person’s condition did require transportation by land ambulance to the nearest acute care hospital, reimbursement will be limited to the amount that would have been paid for land ambulance to that hospital.

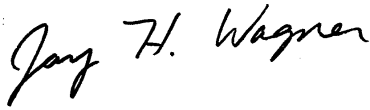
- Within the first three months of a pregnancy, or as soon as reasonably possible and again within forty-eight (48) hours after the actual delivery date if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth; or ninety-six (96) hours for cesarean birth..
- At least two weeks prior to all ambulatory surgery or any ambulatory care procedure when a doctor recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in a free standing ambulatory surgery facility. If precertification cannot be obtained from Medical Management during regular business hours any time prior to surgery, and if a Covered Person receives care as a Hospital inpatient for the types of services which could be performed on an outpatient basis, then we will provide only the reimbursement we would have paid for ambulatory surgery.
- After the 5th Chiropractic visit per provider, per calendar year, to determine medical necessity.

- C. The MMP staff will discuss the planned level of care with you and your attending Participating Physician to determine a level of care which is appropriate to the planned health services and advise you, your attending physician, and the hospital in writing and by telephone of the approved level of care within three (3) business days after the staff receives all the necessary medical information from the attending physician.

The preauthorization of benefits by the MMP does not guarantee payment of benefits. All benefits must be Medically Necessary as determined by us. The payment of benefits is limited by the terms, conditions and limitations of this Certificate.

- D. Please refer to your HMO Member Handbook for a description of how you or your provider can appeal a decision by MMP.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this Rider is attached also apply to this Rider, except where specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President



EMPIRE HEALTHCHOICE HMO, INC.

RIDER TO YOUR BENEFIT CONTRACT OR CERTIFICATE FOR MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE

This Rider adds or changes certain benefits for mental health care and alcohol and substance abuse services under your Contract, Certificate or Group Health Plan, including any applicable Rider(s) thereto. All of the terms, conditions and limitations of the Contract, Certificate or Group Health Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.

- 1. Inpatient Services.** Benefit visit maximums for inpatient care for alcohol and substance abuse detoxification, treatment of mental health care and inpatient rehabilitation for the treatment of alcohol and substance abuse are listed on the Schedule of Benefits attached to your Contract or Certificate.

Coverage for inpatient services for alcohol and substance abuse care is limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Coverage for inpatient services for mental health care is limited to facilities as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law.

- 2. Outpatient Services.** Outpatient services are defined as services provided by an independently billing, licensed health care specialist acting within the scope of his or her license and/or a licensed mental health care or substance abuse facility, hospital or agency. Place of service includes office based, facility, or rural health centers. Type of service includes those services requested via an outpatient treatment report.

Overnight in a hospital (including observation only); and psychological testing are excluded from outpatient services and will continue to require prior authorization prior to the initial visit. Medication management and diagnostic evaluations do not require prior authorization.

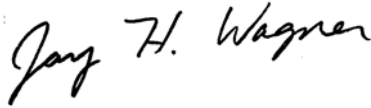
Coverage for outpatient services for alcohol and substance abuse care is limited to facilities in New York State certified by the Office of Alcoholism and Substance Abuse Services (OASAS), or licensed by OASAS as outpatient clinics, or medically supervised ambulatory substance abuse programs, and in other states to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs.

Coverage for outpatient services for mental health care is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health; or when provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 4303 (n) of the New York Insurance Law, a professional corporation or a university faculty practice corporation.

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Precertification of outpatient behavioral health care services is required after an initial 12 visits are exhausted. Upon the thirteenth visit, an outpatient treatment report will be required, and a licensed care manager will review and determine the medical necessity and continued authorization. These first 12 visits will apply per provider, per calendar year. An outpatient treatment report, review and authorization will always be required prior to the thirteenth visit.

3. **Cost-Sharing Requirements and Contract Maximums.** The cost sharing requirements and Contract day maximums for Inpatient, and visit maximums for Outpatient for mental health care and alcohol and substance abuse care are listed on the Schedule of Benefits attached to your Contract or Certificate.
4. **Services Not Covered.** Nothing in the Rider shall be construed to cover benefits for mental health, alcohol and substance abuse services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the Office of Children and Family Services; solely because such services are ordered by a court; that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; that are experimental or investigational treatments; residential treatment services; or that are otherwise excluded under your Contract, Certificate or Group Health Plan.
5. **New Contract after termination of coverage may not contain the benefits of this Rider.** The new Contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President

**EMPIRE HEALTHCHOICE HMO, INC.
RIDER FOR WEBVISIT SERVICES**

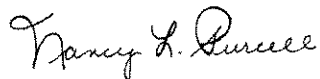
This rider adds benefits for Medically Necessary webVisits to your Contract, Certificate or Group Plan as described below. All of the terms, conditions and limitations of the Contract or Certificate to which this Rider is attached, also apply to this Rider, except where they are specifically changed by this Rider.

1. **WebVisits Defined.** For the purposes of this Rider, **webVisit®** means an on-line interactive consultation between an eligible participating physician and a member who is an existing patient of the physician. The following conditions must be met in order for an on-line consultation to be considered a webVisit and qualify for payment of benefits:
 - A. The physician must have entered into an agreement with Empire and its vendor to conduct webVisits and to accept a negotiated fee for these types of consultations.
 - B. WebVisits are only covered for consultations concerning members who have previously been seen by the participating physician in the physician's office.
 - C. The consultation must be conducted through Empire's website, using the services of a vendor designated by Empire. The member must electronically answer a series of questions concerning his or her health. The answers are then summarized and forwarded through the on-line system to the physician for response.
2. **Covered Services.** Subject to the other provisions of this Rider and your Contract, Certificate or Group Plan, we will provide benefits under this Rider for webVisits.
3. **Services Must Be Received From Eligible Participating Physicians.** Services covered by this Rider must be received from a participating physician who has also agreed to provide webVisits to Empire members and to accept Empire's payment and the member's copayment as full payment for the service. Members may confirm whether their physician is eligible by contacting their physician or by visiting Empire's vendor's website.

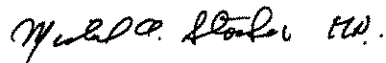
Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association,
an association of Independent Blue Cross and Blue Shield Plans

4. **Deductibles, Copayments and Coinsurance.** Members will be responsible for a \$5 copayment for all webVisits. Members wishing to receive a webVisit will be required to authorize a credit card to make the \$5 copayment on the system hosted by Empire's vendor for each webVisit. The vendor will forward the copayment to the provider. No copayment will be charged for any on-line communications that do not meet the standards of a webVisit. WebVisits will be treated as physician office visits with respect to any deductibles, lifetime or annual benefit limits, and any limits on out-of-pocket costs that may be a part of your Contract, Certificate or Group Plan.
5. **Excluded Services.** Communications consisting of simple messaging, prescription renewal requests, scheduling requests and physician responses that request an in-office visit are not considered webVisits and are not covered. Participating Physicians may not bill members for these types of services.
6. **New Contract After Termination of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Plan ends may not include any of the benefits provided by this Rider.

All of the terms, conditions and limitations of the Contract, Certificate or Group Plan to which this rider is attached also apply to this rider, except where specifically changed by this rider.



Nancy L. Purcell
Corporate Secretary



Michael A. Stocker, M.D.
President
and
Chief Executive Officer



EMPIRE HEALTHCHOICE HMO, INC.

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

This Rider changes provisions in, or adds provisions to, your Contract, Certificate or Group Plan, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively "Your Plan") issued by Empire HealthChoice HMO, Inc. as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Rider, the provisions herein apply to all persons covered under "Your Plan" ("Members").

1. **Emergency Services.**

- A. **Emergency Condition Defined.** The definition of Emergency Condition in Your Plan is hereby deleted in its entirety and replaced with the following:

Emergency Condition. A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

- B. **Emergency Services Defined.** The following definition is hereby added to Your Plan:

Emergency Services. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

- C. **Coverage.** Emergency Services are not subject to prior authorization requirements.

- D. **Cost Sharing.** Any Copayment or Coinsurance requirement in Your Plan that applies to Emergency Services provided by a Non-Participating Provider that differs from the Copayment or Coinsurance required for Emergency Services provided by a Participating Provider is hereby deleted and replaced with the Copayment or Coinsurance requirement, if any, applicable to Emergency Services provided by Participating Providers.

Services provided by Empire HealthChoice HMO, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

- E. **Your Payments.** You are responsible for any Copayment. We will ensure that you are held harmless for any Non-Participating Provider charges that exceed your Copayment.
2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under Your Plan, benefits for the items and services are hereby added to Your Plan:
- A. Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
 - B. Immunizations pursuant to the Advisory Committee on Immunization Practices (“ACIP”) recommendations; and
 - C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”).

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

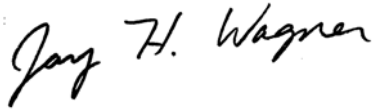
A list of the preventive services covered under this paragraph is available on our website at www.empireblue.com, or will be mailed to you upon request. You may request the list by calling the Customer Service number on your identification card.

3. **Access to OB/GYNs.** Any provision in Your Plan that limits the number of visits you can make to a Participating Provider who specializes in obstetrics or gynecology without a referral from your Primary Care Physician is hereby deleted in its entirety. You do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a Participating Provider who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, contact us at the Customer Service number on your identification card.
4. **Choice of Primary Care Provider.** Your Plan generally requires the designation of a primary care provider (“PCP”). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as a PCP. Until you make this designation, we will designate one for you. For information on how to select a PCP, and for a list of the Participating PCP’s, contact us at the Customer Service number on your identification card.

5. **Annual Limits.** Any annual dollar limit under Your Plan that applies to Essential Benefits, whether such annual limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted. “Essential Benefits” include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act.
6. **Pre-Existing Conditions.** Under this Rider, the provision, if any, in Your Plan that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Group Health Plan for a stated period is hereby deleted in its entirety with respect to all Members under the age of 19.
7. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under Your Plan is hereby deleted in its entirety.
8. **Dependent Children Covered to Age 26.** If Your Plan makes coverage of dependents available, this Rider applies to coverage of children as follows:
 - A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under Your Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Rider.

Coverage for Your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while Your Plan remains in effect and the child remains in such condition, if You submit proof of Your child’s incapacity within 31 days of Your child’s attaining age 26.
 - B. “Children” include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.
 - C. A child chiefly dependent upon you for support and for whom you have been appointed the legal guardian by court order is covered. Coverage lasts until the end of the month in which the child turns 26 years of age.
 - D. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self- sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

- E. The provisions of any Rider to Your Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 8 that apply to children under the age of 26.
9. **Material Distribution.** We will provide the group contract holder, and the group contract holder will provide Covered Persons with, identification cards, Certificates, Riders and other materials provided by us to the group contract holder as necessary to inform Members of the terms of their coverage.
10. **Other Provisions.** All of the terms, conditions, and limitations of the Your Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.



Jay H. Wagner
Corporate Secretary



Mark Wagar
President