Empire BlueCross BlueShield

An Anthem Company

GROUP NAME: **Local 19D Health and Welfare Fund**
GROUP NUMBER: **721071-006M, 06MC, 007M, 07MC, 008M, 08MC, 009M, 09MC, 010M, 10MC**
EFFECTIVE DATE: **1/1/20**

This is Your

Empire PPO

BENEFIT BOOKLET

Issued by: Empire HealthChoice Assurance, Inc.

This Benefit Booklet ("Booklet") explains the benefits available to You under the health care plan (the "Plan") offered by Your Employer.

You should read this Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will allow You to use Your benefits wisely. If You have any questions about the benefits shown in this Booklet, please call the Customer Service number on the back of Your Identification Card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling Customer Service at the number on the back of Your Identification Card.

Important

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

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

NY 2020

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You should read this Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will allow You to use Your benefits wisely. If You have any questions about the benefits shown in this Booklet, please call the Customer Service number on the back of Your Identification Card.

The Plan benefits described in this Booklet are for eligible Members only. The health care services are subject to the limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Booklet. Any group plan or Booklet which You received before will be replaced by this Booklet.

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

Many words used in the Booklet have special meanings (e.g., Employer, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet You will also see references to "We", "Us", "Our", "You", and "Your". The words "We", "Us", and "Our" mean the Claims Administrator. The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

If You have any questions about Your Plan, please be sure to call Customer Service at the number on the back of Your Identification Card. Also be sure to check the Claims Administrator's website, *www.empireblue.com* for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips.

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

This Booklet offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in the network applicable to Your plan as indicated in the Schedule of Benefits section of this Booklet. You should always consider receiving health care services first through the in-network benefits portion of this Booklet.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Booklet provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

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FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

CHOICE OF PRIMARY CARE PHYSICIAN

We generally allow the designation of a Primary Care Physician (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 information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, *www.empireblue.com*. For children, you may designate a pediatrician as the PCP.

ACCESS TO OBSTETRICAL AND GYNECOLOGICAL (OBGYN) CARE

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, 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 health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to Our website, *www.empireblue.com*.

ADDITIONAL FEDERAL NOTICES

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Employer 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 Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

STATEMENT OF RIGHTS UNDER THE WOMEN'S CANCER RIGHTS ACT OF 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If You would like more information on WHCRA benefits, call Us at the number on the back of Your Identification Card.

COVERAGE FOR A CHILD DUE TO A QUALIFIED MEDICAL SUPPORT ORDER ("QMCSO")

If You or Your spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask the Employer to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, Employer health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits Medical Necessity criteria available upon request.

SPECIAL ENROLLMENT PERIODS

You, Your Spouse or Child, can also enroll for coverage within 31 days of the loss of coverage in another Employer health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other Employer health plan due to:

- Termination of employment;
- Termination of the other Employer health plan;
- Death of the Spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions toward the Employer health plan were terminated; or
- A Child no longer qualifies for coverage as a Child under the other Employer health plan.

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice and Fee payment within 31 days of the loss of coverage. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
- You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and Fee payment within 60 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month.

SCHEDULE OF BENEFITS

Dependent Child(ren) age limit:	Coverage lasts until the end of the month in which the Child turns 26.
Provider Network applicable to this Plan	PPO/EPO Network
Benefit Period	Calendar Year

COST-SHARING	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	None None	$1,000 $2,000	
Out-of-Pocket Limit • Individual • Family	$5,080 $12,700	$4,000 $8,000	

OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	$20 Copayment	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$40 Copayment	30% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	Not covered	See benefit for description
• Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Mammography Screenings*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Sterilization Procedures for Women*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Vasectomy	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible	See benefit for description
• All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible	See benefit for description

• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	Covered in full up to the maximum allowed amount	See benefit for description
Non-Emergency Ambulance Services	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if Hospital admission	$300 Copayment not subject to Deductible	Covered same as in-network	See benefit for description
Urgent Care Center	$20 Copayment	$20 Copayment not subject to Deductible	See benefit for description Out-of-network Covered same as in-network for an Emergency Condition
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	Covered in full	Not covered	See benefit for description
Advanced Imaging Services • Performed in an Office Setting • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 $50 Copayment $50 Copayment $50 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Allergy Testing and Treatment Testing • Performed in a PCP Office • Performed in a Specialist Office Treatment • Performed in a PCP Office • Performed in a Specialist Office	 Covered in full Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	$75 Copayment	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	Covered in full	30% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	Use Cost-Sharing for appropriate Service	30% Coinsurance after Deductible	See benefits for description
Cardiac Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $40 Copayment $20 Copayment Included as part of Inpatient Hospital service Cost-Sharing	 30% Coinsurance after Deductible 30% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	Unlimited visits per Benefit Period
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Chiropractic Services • Performed in PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $20 Copayment $40 Copayment $20 Copayment	 Not covered Not covered Not covered	See benefit for description
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Home Health Care	Covered in full	30% Coinsurance not subject to Deductible	200 visits per Benefit Period

Infertility Services • Artificial Insemination • In Vitro fertilization, GIFT, ZIFT	Use Cost-Sharing for appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Use Cost-Sharing for appropriate Service Use Cost-Sharing for appropriate Service	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Use Cost-Sharing for appropriate service Not covered	See benefit for description 3 Cycles per lifetime
Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	 Covered in full Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible Not covered	See benefit for description Home Infusion provided by Home Health Agency counts toward Home Health Care visit limits
Inpatient Medical Visits	Covered in full	30% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Maternity and Newborn Care • Global fee for the prenatal/postnatal and delivery services – Maternity Visits	Covered in full	30% Coinsurance after Deductible	See benefit for description
• Non-global fee (if You change Providers during pregnancy) – Prenatal Care o Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance after Deductible	
o Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
• Physician and Midwife Services for Delivery	Covered in full	30% Coinsurance after Deductible	
• Postnatal Care	Covered in full	30% Coinsurance after Deductible	
• Inpatient Hospital Services and Birthing Center	Included as part of Inpatient Hospital service Cost-Sharing	30% Coinsurance after Deductible (Birthing Center not Covered)	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early

• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Covered in full	30% Coinsurance after Deductible	One (1) breast pump per pregnancy for the duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$75 Copayment	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing	Covered in full	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in a PCP Office • Performed in a Specialist Office • Performed in Outpatient Facilities	 Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	
Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 Covered in full Covered in full Covered in full	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Physical Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 Covered in full Covered in full Covered in full	 Not covered Not covered Not covered	30 visits per Benefit Period
Occupational and Speech Therapies • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 Covered in full Covered in full Covered in full	 Not covered Not covered Not covered	30 combined visits per Benefit Period
Second Opinions on the Diagnosis of Cancer, Surgery and Other • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $20 Copayment $40 Copayment Covered in full	Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when authorization is obtained 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description

Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)			See benefit for description
• Inpatient Hospital Surgery	$500 Copayment per admission, up to $1,250 Copayment maximum per Benefit Period; not subject to Deductible	30% Coinsurance after Deductible	
• Outpatient Hospital Surgery	$75 Copayment	30% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	$75 Copayment	30% Coinsurance after Deductible	
• Surgery Performed in a PCP Office	Covered in full	30% Coinsurance after Deductible	
• Surgery Performed in a Specialist Office	Covered in full	30% Coinsurance after Deductible	
Telemedicine Program			See benefit for description
• Performed by *www.livehealthonline.com*	$20 Copayment	Not covered	
• Performed by a PCP	$20 Copayment	30% Coinsurance after Deductible	
• Performed by a Specialist	$40 Copayment	30% Coinsurance after Deductible	
Vision Therapy			See benefit for description
• Performed in a PCP Office	Covered in full	Not covered	
• Performed in a Specialist Office	Covered in full	Not covered	

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment, Supplies and Insulin (Up to a 30-day supply)	Covered in full	Covered in full up to the Allowed Amount	
• Diabetic Education			
– Performed in a PCP Office	Covered in full	Covered in full up to the Allowed Amount	
– Performed in a Specialist Office	Covered in full	Covered in full up to the Allowed Amount	
– Performed as Outpatient Hospital Services	Covered in full	Covered in full up to the Allowed Amount	
Durable Medical Equipment and Braces	Covered in full	Not covered	See benefit for description
Hospice Care			210 days per lifetime
• Inpatient	Covered in full	Not covered	
• Outpatient	Covered in full	Not covered	
Medical Supplies			See benefit for description
• Performed in an Office Setting or by a third-party supplier	Covered in full	Covered same as in-network	
• Performed as Outpatient Hospital Services	Covered in full	30% Coinsurance after Deductible	
Orthotics Includes Shoe Inserts (non-routine): -For Ages 16 and under, allow 4 inserts every 12 months -For Ages 17 and older, allow 2 inserts every 12 months	Covered in full	Not covered	See benefit for description

Prosthetic Devices	Covered in full	Not covered	See benefit for description
Wigs	Covered in full	Not covered	
Lenses and/or Glasses after cataract surgery 2 per lifetime	Covered in full	Not covered	See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement	$500 Copayment per admission, up to $1,250 Copayment maximum per Benefit Period; not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility	Covered in full	Not covered	90 days per Benefit Period
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	$500 Copayment per admission, up to $1,250 Copayment maximum per Benefit Period; not subject to Deductible	30% Coinsurance after Deductible	30 days per Benefit Period
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	$500 Copayment per admission, up to $1,250 Copayment maximum per Benefit Period; not subject to Deductible	30% Coinsurance after Deductible	Unlimited days per Benefits Period
Outpatient Mental Health Care • Office Visits • All Other Outpatient Services	 $20 Copayment $20 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	Unlimited visits per Benefit Period

Inpatient Substance Use Treatment for a continuous confinement when in a Hospital (including Residential Treatment)	$500 Copayment per admission, up to $1,250 Copayment maximum per Benefit Period; not subject to Deductible	30% Coinsurance after Deductible	Unlimited days per Benefits Period
Outpatient Substance Use Services			Unlimited visits per Benefit Period
• Office Visits	$20 Copayment	30% Coinsurance after Deductible	
• All Other Outpatient Services	$20 Copayment	30% Coinsurance after Deductible	

DEFINITIONS

Defined terms will appear capitalized throughout this Booklet.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Administrative Services Agreement: The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Benefit Period: The length of time We will cover benefits for Covered Services. The Schedule of Benefits section of this Booklet shows if Your Plan's Benefit Period is a Calendar Year or a Plan Year. If Your coverage ends before the end of the year, then Your Benefit Period also ends.

Calendar Year: A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Booklet.

Claims Administrator: The company the Employer chose to administer its health benefits. Empire BlueCross BlueShield was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Booklet.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such 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. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Employee: A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer: An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Exclusions: Health care services that We do not pay for or Cover.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a Facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder

outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analysis; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Plan.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Booklet for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Fees have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Non-Participating Provider: A Provider who does not have an agreement or contract with Us or another Blue Cross and/or Blue Shield plan to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Pocket Limit: The most You pay during a Benefit Period in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Fee, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us or another Blue Cross and/or Blue Shield plan to provide services to You. A list of Participating Providers and their locations is available on Our website at *www.empireblue.com* or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator: The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. The Plan Administrator is not the Claims Administrator.

Plan Sponsor: The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is not the Claims Administrator.

Plan Year: The length of time We will cover benefits for Covered Services. The Plan Year can be either the 12-month period beginning on the effective date of the Plan or any anniversary date thereafter, during which the Plan is in effect or a calendar year ending on December 31 of each year. If Your coverage ends before the end of the year, then Your Plan Year also ends. The Schedule of Benefits section of this Certificate shows if Your Plan's Benefit Period is a Plan Year or a Calendar Year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Preauthorization section of this Booklet.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

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

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Booklet or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Booklet that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits and other limits on Covered Services.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Booklet is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Empire HealthChoice Assurance, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Plan.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

HOW YOUR COVERAGE WORKS

A. **Your Coverage Under this Plan.** Your Employer has purchased a health insurance Plan from Us. We will provide the benefits described in this Booklet to covered Members of the Employer, that is, to employees of the Employer and their covered Dependents.

B. **Covered Services.** You will receive Covered Services under the terms and conditions of this Plan only when the Covered Service is:
- Medically Necessary;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Booklet; and
- Received while Your Plan is in force.

C. **Participating Providers.** To find out if a Provider is a Participating Provider, and for details about licensure and training:
- Check Your Provider directory, available at Your request,
- Call the number on Your ID card; or,
- Visit Our website at *www.empireblue.com.*

D. **The Role of Primary Care Physicians.** This Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). You do not need a Referral from a PCP before receiving Specialist care.

You may need to request Preauthorization before You receive certain services. See the Preauthorization section of this Booklet for the services that require Preauthorization.

1. **Access to Providers and Changing Providers.** Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

   To see a Provider, call his or her office and tell the Provider that You are an Empire Member in the network applicable to Your plan as indicated in the Schedule of Benefits section of this Booklet, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

E. **Out-of-Network Services.** We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Booklet for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

F. **Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Services.

1) You are responsible for requesting Preauthorization for the in-network and out-of-network services listed below:

- All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns;
- Inpatient Mental Health Care, Substance Use Services;
- Mental Health and Substance Use Intensive Outpatient Program Services;
- Mental Health and Substance Use Partial Hospitalization Program Services;
- Skilled Nursing Facility;

- Outpatient/Ambulatory Surgical Treatments;
- Chiropractic Care (after the 5th visit);
- Physical* and Occupational Therapy *
- Speech Therapy;
- Diagnostic Radiology Services;
- Therapeutic Radiology Services;
- Advanced Imaging Services: MRI, MRA
- Durable Medical Equipment*;
- Prosthetics* and Orthotics*
- Genetic Testing.

*Preauthorization not required when services obtained out-of-network

G. **Preauthorization/Notification Procedure.** If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us at the number on Your ID card.

You or Your Participating Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. **Failure to Seek Preauthorization or Provide Notification.** If You fail to seek Our Preauthorization for Out-of-Network benefits or provide notification for benefits subject to this section, We will pay an amount $5,000 less than We would have otherwise paid for the care or We will pay only 50% of the amount We would otherwise have paid for the care whichever results in a greater benefit for You. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service. The penalty listed above will not apply to Medically Necessary inpatient Facility services from a BlueCard Provider.

I. **Medical Management.** The benefits available to You under this Plan are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

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

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; and
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary only if:

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

See the Utilization Review and External Review sections of this Booklet for Your right to an internal Appeal and External Review of Our determination that a service is not Medically Necessary.

K. **Delivery of Covered Services Using Telehealth.** If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Booklet that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

L. **Case Management.** Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other

Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your authorized representative in writing.

M. Important Telephone Numbers and Addresses.

- **CLAIMS**
  Refer to the address on Your ID card

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
  Call the number on Your ID card

- **ASSIGNMENT OF BENEFITS FORM**
  Refer to the address on Your ID card
  (Submit assignment of benefits form for surprise bills to this address.

- **MEDICAL EMERGENCIES AND URGENT CARE**
  Call the number on Your ID card

- **MEMBER SERVICES**
  Call the number on Your ID card
  Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:00 p.m. E.S.T.

- **PREAUTHORIZATION**
  Call the number on Your ID card
- **OUR WEBSITE**
  www.empireblue.com

ACCESS TO CARE AND TRANSITIONAL CARE

A. **Authorization to a Non-Participating Provider.** If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. **When Your Provider Leaves the Network.** If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

   In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, authorizations, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. **New Members In a Course of Treatment.** If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Plan becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Plan. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Plan becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

   In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

COST-SHARING EXPENSES AND ALLOWED AMOUNT

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Booklet for Covered Services during each Benefit Period before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Benefit Period. However, after Deductible payments for persons covered under this Plan collectively total the family Deductible amount in the Schedule of Benefits section of this Booklet in a Benefit Period, no further Deductible will be required for any person covered under this Plan for that Benefit Period.

You have an Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

B. Copayments. Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Booklet for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance. Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Booklet.

You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.

D. Out-of-Pocket Limit. When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Benefit Period. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Plan have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, does not apply toward Your In-Network Out-of-Pocket Limit, and Cost-Sharing for in-network services does not apply towards Your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Booklet does not apply toward Your In-Network Out-of-Pocket Limit.

E. Your Additional Payments for Out-of-Network Benefits. When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Booklet, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim

information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment. Additionally, another example of when We will apply a payment rule to a claim is when You receive services from a Health Care Professional who is not a Physician, such as a physician's assistant. Under the payment rule, the Allowed Amount for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

F. **Allowed Amount.** "Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers in Our Service Area will be determined as follows:

1. **Facilities.** For Facilities, the Allowed Amount will be the average amounts paid by Us for comparable services to Our Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

2. **All Other Providers.** For all other Providers, the Allowed Amount applicable to Your Plan is 330% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality.

See the Inter-Plan Program section below for a description of how We determine the Allowed Amount for Non-Participating Providers outside Our Service Area.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website at *www.empireblue.com* for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

Our payments to Participating Providers may include financial incentives to help improve the quality of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

See the Emergency Services section of this Booklet for the Allowed Amount for Emergency Services. See the Ambulance and Pre-Hospital Emergency Medical Services section of the Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

G. Inter-Plan Programs

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

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

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

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

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

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

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

3. **Special Cases: Value-Based Programs.**

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

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

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

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

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

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

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

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

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

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

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

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

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

WHO IS COVERED

A. **Who is Covered Under this Plan.** You, the Subscriber to whom this Booklet is issued, are covered under this Plan. Members of Your family may also be covered depending on the type of coverage You selected.

B. **Types of Coverage.** We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are Covered.

C. **Children Covered Under this Plan.** If You selected parent and child/children or family coverage, Children covered under this Plan include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the age set forth in the Schedule of Benefits section of this Booklet. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Plan at any time.

D. **When Coverage Begins.** Coverage under this Plan will begin as follows:

1. If You, the Subscriber elect coverage before becoming eligible, or within 60 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Employer. Employers cannot impose waiting periods that exceed 90 days.

2. If You, the Subscriber do not elect coverage upon becoming eligible or within 60 days of becoming eligible for other than a special enrollment period, You must wait until the Employer's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 60 days thereafter, coverage for Your Spouse and Child starts on the date of marriage. If We do not receive notice within 60 days of the marriage, You must wait until the Employer's next open enrollment period to add Your Spouse or Child.

4. If You, the Subscriber, have a newborn or adopted newborn Child, and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth;

otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You 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 Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Fee within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice and the Fee payment.

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

1. Termination of employment;
2. Termination of the other Employer health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the Employer health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other Employer health plan.

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

We must receive notice and Fee payment within 60 days of one of these events. The effective date of Your coverage will be the date indicated on the application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

a. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
b. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

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

PREVENTIVE CARE

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the telephone number on Your ID card or visit Our website at *www.empireblue.com* for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Benefit Period, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

B. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the Covered preventive Services is available on Our website at *www.empireblue.com*, or will be mailed to You upon request.

   You are eligible for a physical examination once every Benefit Period, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

   This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. **Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. **Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating the cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered

preventive Services is available on Our website at *www.empireblue.com*, or will be mailed to You upon request.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

E. **Mammograms.** We Cover mammograms for the screening of breast cancer as follows:
- One (1) baseline screening mammogram for women age 35 through 39; and
- One (1) baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

F. **Family Planning and Reproductive Health Services.** We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered ; patient education and counseling on use of contraceptives and related topics ; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

Family planning and reproductive health services, such as contraceptive drugs and devices and sterilization procedures, are not Covered under the Booklet. You may purchase coverage for these services directly from Us.

G. **Bone Mineral Density Measurements or Testing.** We Cover bone mineral density measurements or tests and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:
- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

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

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

AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. **Pre-Hospital Emergency Medical Services.** We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

   "Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover 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:
   - 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;
   - Serious impairment to such person's bodily functions;
   - Serious dysfunction of any bodily organ or part of such person; or
   - Serious disfigurement of such person.

   An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile.

2. **Emergency Ambulance Transportation.** In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation. We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:
- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.
- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that

transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one (1) of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

EMERGENCY SERVICES AND URGENT CARE

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Emergency Services. We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 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;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services at a non-participating Hospital at the in-network Cost-Sharing for as long as Your medical condition prevents Your transfer to a participating Hospital.

Any inpatient Hospital services received from a non-participating Hospital after Your medical condition no longer prevents Your transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing unless We authorize continued treatment at the non-participating Hospital.

If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer. Any inpatient Hospital services received from a non-participating Hospital after We have notified You and arranged for a transfer to a participating Hospital will be Covered at the out-of-network Cost-Sharing.

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

   You are responsible for any in-network Copayment, Deductible or Coinsurance.

B. **Urgent Care.** Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in or out of Our** Service Area.

   1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.

   2. **Out-of-Network.** We Cover Urgent Care from non-participating Urgent Care Centers or Physicians.

   If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

OUTPATIENT AND PROFESSIONAL SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. **Acupuncture.** We Cover acupuncture services rendered by a Health Care Professional licensed to provide such services.

B. **Advanced Imaging Services.** We Cover PET scans, MRI, nuclear medicine, and CAT scans.

C. **Allergy Testing and Treatment.** We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. **Ambulatory Surgical Center Services.** We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. **Chemotherapy.** We Cover chemotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy may be administered by injection or infusion.

F. **Chiropractic Services.** We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Booklet.

G. **Clinical Trials.** We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:
   - Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
   - Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

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

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

   An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:
   - A federally funded or approved trial;
   - Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
   - A drug trial that is exempt from having to make an investigational new drug application.

H. **Dialysis.** We Cover dialysis treatments of an Acute or chronic kidney ailment.

I. **Home Health Care.** We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility.

Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse; and
- Part-time or intermittent services of a home health aide; and
- Physical, occupational, or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to the number of visits on the Schedule of Benefits section of this Booklet. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services benefits.

J. **Infertility Treatment.** We Cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:

   - Initial evaluation,
   - Semen analysis,
   - Laboratory evaluation,
   - Evaluation of ovulatory function,
   - Postcoital test,
   - Endometrial biopsy,
   - Pelvic ultra sound,
   - Hysterosalpingogram,
   - Sono-hystogram,
   - Testis biopsy,
   - Blood tests, and
   - Medically appropriate treatment of ovulatory dysfunction.

   Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:

   - Ovulation induction and monitoring;
   - Pelvic ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Advanced Reproductive Technologies (ART) Services.** The following services are covered to Covered Persons who have failed to achieve a pregnancy after 12 months of appropriate, timed

unprotected intercourse or therapeutic donor insemination (or six months for women age 35 and over). These services are available on an In-Network basis only from Participating Providers who are members of and contribute data to the Society of Assisted Reproductive Technologies.

a. Three (3) Cycles of advanced reproductive technologies, including:
   i. In Vitro Fertilization (IVF)
   ii. Frozen Embryo Transfer (FET)
   iii. Zygote Intrafallopian Transfer (ZIFT)
   iv. Gamete Intrafallopian Transfer (GIFT)
   v. Intracytoplasmic Sperm Injection (ICSI)

b. Medically necessary and appropriate diagnostic workup and radiology services.

c. Pathology and laboratory services, including:
   i. Hormonal assays
   ii. Swimup semen analysis, as appropriate
   iii. Ultrasound exams
   iv. Fertilization and embryo culture
   v. Ova retrieval
   vi. Embryo, gamete-zygote transfer
   vii. Cryo preservation of blastocysts(s) and embryo(s) from covered IVF Cycles and oocytes as directed by Medical policy and up to the age of forty-five (45).

a. Medications necessary to the provisions above, including parenteral injection and oral ovulation induction drugs.

b. We will provide benefits for no more than three (3) Cycles of Assisted Reproductive Technologies per lifetime. A Cycle which is started, but is not completed is considered a cancelled Cycle. Cancelled Cycles will count towards the lifetime maximum as follows:

   i. First covered Cycle – three (3) cancelled Cycles shall count as the first Cycle even if no transfer is performed.
   ii. Second covered Cycle – two (2) cancelled Cycles shall count as the second Cycle even if no transfer is performed.
   iii. Third covered Cycle – two (2) cancelled Cycles shall count as the third Cycle even if no transfer is performed.

   - A "Cycle" is defined as either:

     i. all treatment that starts when preparatory medications used for ovarian stimulation with the intent of undergoing ART is administered for oocyte retrieval, IVF and fresh embryo transfer, or
     ii. all treatment that may start with medications for endometrial preparation with the intent of undergoing ART for purposes of frozen embryo transfer.

   - A Cancelled Cycle is defined as one in which ovarian stimulation has been carried out with the intent of undergoing ART but which did not proceed to oocyte retrieval, or in the case of frozen embryo Cycles, to the transfer of embryos.

c. All frozen embryos stored after a completed Cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation Cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen Cycles) and elective single embryo transfer should be utilized when clinically appropriate.

4. **Exclusions and Limitations.** We do not Cover:

a. Related donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications).
b. Fallopian tube ligations and vasectomy reversals.
c. Surrogacy and any fees associated with it (maternity services are covered for Members acting as a surrogate mother).
d. Medical and surgical procedures that are experimental or investigational.
e. Services requested which are not medically appropriate.
f. Services not specifically listed as covered directly above.
g. Services rendered by non-participating providers, unless authorized by the Medical Management Program.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.

K. Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

L. Interruption of Pregnancy. We Cover therapeutic abortions including abortions in cases of rape, incest or fetal malformation (i.e., medically necessary abortions). We Cover elective abortions.

M. Laboratory Procedures, Diagnostic Testing and Radiology Services. We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care. We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Booklet for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding.

O. Office Visits. We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

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

P. **Outpatient Hospital Services.** We Cover Hospital services and supplies as described in the Inpatient Services section of this Booklet that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Q. **Preadmission Testing.** We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. **Prescription Drugs for Use in the Office and Outpatient Facilities.** We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You.

When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Booklet.

S. **Rehabilitation Services.** We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to the number of visits listed on the Schedule of Benefits section of this Booklet.

T. **Retail Health Clinics.** We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses.

U. **Second Opinions.**

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written authorization to a non-participating Specialist

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
   a. The second opinion must be given by a board certified Specialist who personally examines You.
   b. If the first and second opinions do not agree You may obtain a third opinion.
   c. The second and third surgical opinion consultants may not perform the surgery on You.

3. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that We designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third

opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

V. **Surgical Services.** We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

- **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount.

- **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
  a. For the procedure with the highest Allowed Amount; and
  b. 50% of the amount We would otherwise pay for the other procedures.

W. **Oral Surgery.** We Cover the following limited dental and oral surgical procedures:

1. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
2. Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
3. Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
4. Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
5. Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. **Reconstructive Breast Surgery.** We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. **Other Reconstructive and Corrective Surgery.** We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:
- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. **Telemedicine Program.** In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program.

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

Member Access. To begin the online visit, go to *www.empireblue.com* and log in to Your member account or, if You do not already have one, set up an online account by providing some basic information about You and Your insurance plan. Then, follow the prompts that will guide You to an online visit. Before You connect to a Doctor, You will be asked to identify: the kind of condition and symptoms You want to discuss with the Doctor, list Your local pharmacy, provide information for the credit card You want Your cost share for the visit to be billed to, agree to the terms of use, and select an available Physician. If You are not in New York State when You seek an online visit, You will need to check to be sure an online Doctor is available in the state You are in because online Doctors are not available in every state. Please refer to the Schedule of Benefits for any Cost-Sharing requirements that apply.

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

Note about Covered Services. Online visits are not meant for the following purposes:

- To request an office appointment;
- To ask billing, insurance coverage or payment questions;
- To ask for a referral to a specialist Doctor;
- To request Preauthorization for a benefit under your health Plan; or
- To ask the Physician to consult with another Physician.

AA. Transplants. We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

To maximize Your benefits, You should call Our Transplant Department to as soon as You think You may need a transplant to talk about Your benefit options. You must do this before You have an evaluation and/or work-up for a transplant. We will help You maximize Your benefits by giving You coverage information, including details on what is Covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Member Services number on the back of Your ID card and ask for the transplant coordinator. Even if We give a prior approval for the Covered Transplant Procedure, You or Your

Provider must call Our Transplant Department for Preauthorization prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Preauthorization is required for before We will Cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Preauthorization to Us as soon as possible to start this process. Not getting Preauthorization will result in a denial of benefits

Please note that there are cases where Your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be Covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

BB. Vision Therapy. We Cover vision therapy to improve vision skills, such as eye movement control and eye coordination.

ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. **Diabetic Equipment, Supplies and Self-Management Education.** We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.** We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
    - Acetone reagent strips
    - Acetone reagent tablets
    - Alcohol or peroxide by the pint
    - Alcohol wipes
    - All insulin preparations
    - Automatic blood lance kit
    - Blood glucose kit
    - Blood glucose strips (test or reagent)
    - Blood glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
    - Cartridges for the visually impaired
    - Diabetes data management systems
    - Disposable insulin and pen cartridges
    - Drawing-up devices for the visually impaired
    - Equipment for use of the pump
    - Glucagon for injection to increase blood glucose concentration
    - Glucose acetone reagent strips
    - Glucose reagent strips
    - Glucose reagent tape
    - Injection aides
    - Injector (Busher) Automatic
    - Insulin
    - Insulin cartridge delivery
    - Insulin infusion devices
    - Insulin pump
    - Lancets
    - Oral agents such as glucose tablets and gels
    - Oral anti-diabetic agents used to reduce blood sugar levels
    - Syringe with needle; sterile 1 cc box
    - Urine testing products for glucose and ketones
    - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. **Self-Management Education.** Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or

when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. **Limitations.** The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise medically necessary.

B. **Durable Medical Equipment and Braces.** We Cover the rental or purchase of durable medical equipment and braces.

1. **Durable Medical Equipment.**
Durable Medical Equipment is equipment which is:
   - Designed and intended for repeated use;
   - Primarily and customarily used to serve a medical purpose;
   - Generally not useful to a person in the absence of disease or injury; and
   - Appropriate for use in the home.

   Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment..

   We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.** We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

C. **Hospice.** Hospice Care is available if Your primary attending Physician has certified that You have twelve (12) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Booklet. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located.

We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker or caretaker care.

D. **Medical Supplies.** We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under the Plan. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under the Plan. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

E. **Orthotics.** We Cover orthotics (e.g., shoe inserts) that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We Cover replacements: due to a change in Your condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

F. **Prosthetics:**

1. **External Prosthetic Devices.** We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease . We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

   We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

   We do not Cover contact lenses.

   We do not Cover foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

   We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

   Coverage is for standard equipment only.

2. **Internal Prosthetic Devices:** We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

   Coverage also includes repair and replacement due to normal growth or normal wear and tear.

   Coverage is for standard equipment only.

INPATIENT SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Hospital Services. We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, xray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Booklet apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services. We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services. We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under the Plan.

D. Inpatient Stay for Maternity Care. We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under the Plan and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Booklet that apply to home care benefits.

E. Inpatient Stay for Mastectomy Care. We Cover inpatient services for Members undergoing a lymph

node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. **Autologous Blood Banking Services.** We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. **Rehabilitation Services.** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Booklet.

H. **Skilled Nursing Facility.** We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in Hospital Services above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Booklet). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. Coverage for non-custodial care is limited to the number of days indicated on the Schedule of Benefits section of this Booklet.

I. **End of Life Care.** If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited External Review. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Booklet until the External Review renders a decision in Our favor.

   We will reimburse Non-Participating Providers for this end of life care as follows:
   1. We will reimburse a rate that has been negotiated between Us and the Provider.
   2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
   3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. **Limitations/Terms of Coverage.**

   1. When You are receiving inpatient care in a Facility, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
   2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
   3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care.

MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. **Mental Health Care Services.** We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical, and surgical coverage provided under the Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 (10), such as:
   - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
   - A state or local government run psychiatric inpatient Facility;
   - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
   - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

   and, in other states, to similarly licensed or certified Facilities.

   We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the New York Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

B. **Substance Use Services.** We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder. This includes Coverage for detoxification and rehabilitation

services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

EXCLUSIONS AND LIMITATIONS

No coverage is available under this Plan for the following:

A. **Aviation.** We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. **Convalescent and Custodial Care.** We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

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

D. **Cosmetic Services.** We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Review sections of this Booklet unless medical information is submitted.

E. **Coverage Outside of the United States, Canada or Mexico.** We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Urgent Care, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. **Dental Services.** We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Booklet.

G. **Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Booklet,. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Plan for non-investigational treatments. See the Utilization Review and External Review sections of this Booklet for a further explanation of Your Appeal rights.

H. **Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services

involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. **Foot Care.** We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. **Gene Therapy.** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

K. **Government Facility.** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

L. **Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary.

M. **Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, We will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

N. **Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

O. **No-Fault Automobile Insurance.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

P. **Services Not Listed.** We do not Cover services that are not listed in this Booklet as being Covered.

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

R. **Services Separately Billed by Hospital Employees.** We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

S. **Services with No Charge.** We do not Cover services for which no charge is normally made.

T. **Vision Services.** We do not Cover the examination or fitting of contact lenses.

U. **War.** We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

V. **Workers' Compensation.** We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

CLAIM DETERMINATIONS

A. **Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Booklet for information on how We coordinate benefit payments when You also have health coverage with another plan.

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

C. **Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit it as soon as reasonably possible.

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

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

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

F. **Pre-Service Claim Determinations.**

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

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

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

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

GRIEVANCE PROCEDURES

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

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

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

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

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

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

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

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

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

Expedited/Urgent Grievances:	The earlier of two 2 business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

UTILIZATION REVIEW

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

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

B. Preauthorization Reviews.

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

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

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

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

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

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

C. Concurrent Reviews

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

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

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

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

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

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

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

E. Retrospective Review of Preauthorized Services. We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;

- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. **Reconsideration.** If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

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

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

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
   - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
   - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

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

- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. First Level Appeal.

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

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

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

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

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

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

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

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

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

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

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

EXTERNAL REVIEW

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

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

This section applies when You also have health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. "Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. "Plan" is other group health coverage 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 group 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 school or organization pays the premium or Fees.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. "Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. "Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment. The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Plan will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
    - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. **Effects of Coordination.** When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. **Right to Receive and Release Necessary Information.** We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. **Our Right to Recover Overpayment.** If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. **Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.** Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Plan is primary, as defined in this section, We will pay benefits first.
2. If this Plan is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, We will make any necessary adjustments.

TERMINATION OF COVERAGE

Coverage under the Plan will automatically be terminated on the first of the following to apply.

1. The Employer and/or Subscriber has failed to pay Fees within 30 days of when Fees are due. Coverage will terminate as of the last day for which Fees were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Employer.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Fee had been paid.

4. For Spouses in cases of divorce the date of the divorce

5. For Children, until the Child turns the maximum age indicated on the Schedule of Benefits section of this Booklet.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month during which the Employer or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Plan. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Administrative Services Only Agreement between the Employer and Us terminates.

10. The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

11. The Employer has failed to comply with a material plan provision relating to Employer participation rules. We will provide written notice to the Employer and Subscriber at least 30 days prior to when the coverage will cease.

12. The Employer ceases to meet the statutory requirements to be defined as an Employer for the purposes of obtaining coverage. We will provide written notice to the Employer and Subscriber at least 30 days prior to when the coverage will cease.

13. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Booklet for Your right to continuation of this coverage.

CONTINUATION OF COVERAGE

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

A. **Qualifying Events.** Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Plan in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Divorce or legal separation from the Subscriber; or
   - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
   - Loss of covered Child status under the plan rules; or
   - Death of the Subscriber.

   If You want to continue coverage You must request continuation from the Employer in writing and make the Fee payment within the 60-day period following the later of:

   1. The date coverage would otherwise terminate; or
   2. The date You are sent notice by first class mail of the right of continuation by the Employer.

   Continued coverage under this section will terminate at the earliest of the following:
   1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment;
   2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
   3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
   4. The date You become entitled to Medicare;
   5. The date to which Fees are paid if You fail to make a timely payment; or
   6. The date the Administrative Services Only Agreement between the Employer and Us terminates. However, if the Administrative Services Only Agreement is replaced with similar coverage, You have the right to become covered under the new Plan for the balance of the period remaining for Your continued coverage.

B. Supplementary Continuation, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Employer does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than four (4) years of active duty.

When Your Employer does not voluntarily maintain Your coverage during active duty, coverage under the Plan will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Employer the required Fee but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Plan may be resumed as long as You are reemployed or restored to participation in Your Employer's Plan upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Employer's Plan upon return to civilian status, You will be eligible for continuation as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and You have a right to a Recovery or have received a Recovery from any source.

A. **Recovery.** A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

C. **Reimbursement.** If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to

any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

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

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

GENERAL PROVISIONS

1. **Agreements Between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Plan does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.** You cannot assign any benefits under the Plan or legal claims based on a denial of benefits or request for plan documents to any person, corporation, or other organization. You cannot assign any monies due under the Plan to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Booklet for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits or request for plan documents by You other than for monies due for a surprise bill will be void. Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under the Plan or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Any purported assignment of benefits shall be void. Any purported assignee of benefits shall acquire no rights by reason of any such purported assignment. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. **Changes in This Booklet.** We may unilaterally change this Booklet upon renewal, if We give the Employer 30 days' prior written notice.

4. **Clerical Error.** Clerical error, whether by the Employer or Us, with respect to this Plan, or any other documentation issued by Us in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. **Conformity with Law.** Any term of this Plan which is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

6. **Continuation of Benefit Limitations.** Some of the benefits of this Plan may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

7. **Enrollment ERISA.** The Employer will 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 Members covered under this Plan, and any other information required to confirm their eligibility for coverage.

   The Employer will provide Us with this information upon request. The Employer may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Employer, or a third party appointed by the Employer. We are not the ERISA plan administrator

   The Employer will provide Us with the enrollment form including Your name, address, age, and social security number and 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 of the Administrative Services Agreement with Us. If the Employer fails to so advise Us, the Employer 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 thirty (30) days.

8. **Entire Agreement.** This Booklet, including any endorsements, riders and the attached applications,

if any, constitutes the entire Plan.

9. **Fraud and Abusive Billing.** We have processes to review claims before and after payment to detect fraud and abusive billing.

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

10. **Furnishing Information and Audit.** The Employer and all persons covered under this Plan will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Plan. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Employer will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Employer enrollment at the Employer's New York office.

11. **Identification Cards.** Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Plan. To be entitled to such services or benefits, Your Fees must be paid in full at the time the services are sought to be received.

12. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties

13. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. **Input in Developing Our Policies.** Subscribers may participate in the development of Our policies by calling or writing to Member Services. We encourage You to send suggestions about how We may improve Our products or Our policies and procedures. Also, We regularly conduct customer satisfaction surveys that permit You to share Your suggestions and opinions with Us.

15. **Material Accessibility.** We will give the Employer, and the Employer will give You, ID cards, Booklets, riders, and other necessary materials

16. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Plan. Upon Your request, We will provide the following information:
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Plan.
    - A written description of Our quality assurance program.
    - A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
    - Provider affiliations with participating Hospitals.
    - A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or

Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.

- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under this Plan.

17. **Notice.** Any notice that We give You under this Plan will be mailed to Your address as it appears in Our records or to the address of the Employer. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Empire Member Services, P.O. Box 1407, Church Street Station, New York, NY 10008.

18. **Premium Refund.** We will give any refund of Fees, if due, to the Employer.

19. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

20. **Renewal Date.** The renewal date for this Plan is the anniversary of the effective date of the Employer Administrative Services Only Agreement of each year. This Plan will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by this Plan, or by the Employer upon 30 days' prior written notice to Us.

21. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will or will not make payments under this Plan. Examples of the use of the standards are to determine whether Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Booklet. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Plan.

22. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

23. **Service Marks.** Empire HealthChoice Assurance, Inc. ("Empire") is an independent corporation organized under the New York Insurance Law. Empire also operates under licenses with the Blue Cross and Blue Shield Association, which licenses Empire to use the Blue Cross and/or 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. Empire is solely responsible for the obligations created under this agreement.

24. **Severability.** The unenforceability or invalidity of any provision of this Plan shall not affect the validity and enforceability of the remainder of this Plan.

25. **Significant Change in Circumstances**. If We are unable to arrange for Covered Services as provided under this Plan as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of

Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

26. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Plan and nothing in this Plan shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Plan. No other party can enforce this Plan's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Plan, or to bring an action or pursuit for the breach of any terms of this Plan.

27. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Plan. You must start any lawsuit against Us under this Plan within two (2) years from the date the claim was required to be filed.

28. **Venue for Legal Action.** If a dispute arises under this Plan, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

29. **Waiver.** The waiver by any party of any breach of any provision of this Plan will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. **Who May Change This Plan.** This Plan may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Plan in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

31. **Who Receives Payment Under This Plan.** Payments under this Plan for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Booklet for more information about surprise bills.

32. **Workers' Compensation Not Affected.** The coverage provided under this Plan is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. **Your Medical Records and Reports.** In order to provide Your coverage under this Plan, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Plan, except as prohibited by law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and

- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted by law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

34. Your Rights and Responsibilities.

- You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.
- You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- You have the right to formulate advance directives regarding Your care.
- You have the right to access Our Participating Providers.

As a Member, You should also take an active role in Your care. We encourage You to:

- Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
- Follow the treatment plan that You have agreed on with Your doctors or Providers;
- Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Certificate. This may include information about other health insurance benefits You have along with Your coverage with Us; and
- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

For additional information regarding Your rights and responsibilities, visit the FAQs on Our website at *www.empireblue.com*. If You do not have internet access, You can call Us at the number on Your ID card to request a copy. If You need more information or would like to contact Us, please go to Our website at *www.empireblue.com* or call Us at the number on Your ID card.

Get help in your language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yiddish

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

It's important we treat you fairly

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