Dutchess Educational Health Insurance Consortium Healthy Advantage PPO

PPO

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11/2013

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Welcome!

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

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

YOUR PPO – A SMART WAY TO GET HEALTHCARE

Your PPO, or Preferred Provider Organization, is a group healthcare plan available to you through an insurance policy issued and underwritten by Empire BlueCross BlueShield. The PPO offers a network of healthcare providers available to you through Empire. If you think about your town, it includes doctors, hospitals, laboratories and other medical facilities that provide healthcare services – that's what we mean by healthcare "providers." Some healthcare providers contract with health plans like Empire BlueCross BlueShield to provide services to members as part of the plan's "network."

With Empire's PPO, when you need healthcare services, you have a choice. Depending on the healthcare service you need, you are free to get care from providers participating in your PPO network or you can choose to use outside providers. You are covered for medically necessary services no matter which you choose.

WHAT'S THE EMPIRE PPO ADVANTAGE?

When you use Empire's PPO network to access healthcare, you get:

- A comprehensive Web site, *www.empireblue.com*, for fast, personalized, secure information
- Among the largest network of doctors and hospitals in New York State
- Providers that are continuously reviewed for Empire's high standards of quality
- The ability to choose in-network or out-of-network care for most covered services
- Minimal out-of-pocket costs for preventive care, behavioral healthcare and a wide variety of hospital and medical services when you stay in-network
- Easy to use – no claim forms to file when you stay in-network
- Coverage for you and your family when traveling or living outside of Empire's service area

HOW TO USE THIS GUIDE

This Guide gives you an overview of the features and benefits of your plan. Use it as a reference to find out what's covered, what your costs are, and how to get healthcare services any time you or a covered family member need them.*

You'll find the information you need divided into sections. Here's a quick reference:

	IF YOU ARE LOOKING FOR …	YOU'LL FIND IT IN	ON PAGE
•	HOW THE PLAN WORKS	USING YOUR PPO	6
•	WHAT'S COVERED	COVERAGE	21
•	PRECERTIFICATION AND HEALTH INFORMATION	HEALTH MANAGEMENT	27
•	HOW TO FILE A CLAIM, THE MEANING OF HEALTHCARE TERMS, AND YOUR LEGAL RIGHTS	DETAILS AND DEFINITIONS	34

OUR ROLE IN NOTIFYING YOU

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

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

Manage Your Healthcare Online!

REGISTER NOW TO DO IT ON THE WEB!

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

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

Plus much more …

HERE'S WHAT YOU'LL NEED TO DO

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

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

GET PERSONALIZED HEALTH INFORMATION – INCLUDING YOUR HEALTH IQ

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

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

Get health information for you and your family.

YOUR PRIVACY IS PROTECTED

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

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

Your PPO Guide

Introduction

Getting Answers Your Way

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

ON THE INTERNET

Do you have customer service inquiries and need an instant response? Visit *www.empireblue.com*. At Empire, we understand that getting answers quickly is important to you. Most benefit, claims or membership questions can be addressed online quickly, simply and confidentially. Nervous about using your PC for important healthcare questions or transactions? We've addressed that too! Just "click to talk" to a representative or send us an e-mail.

BY TELEPHONE

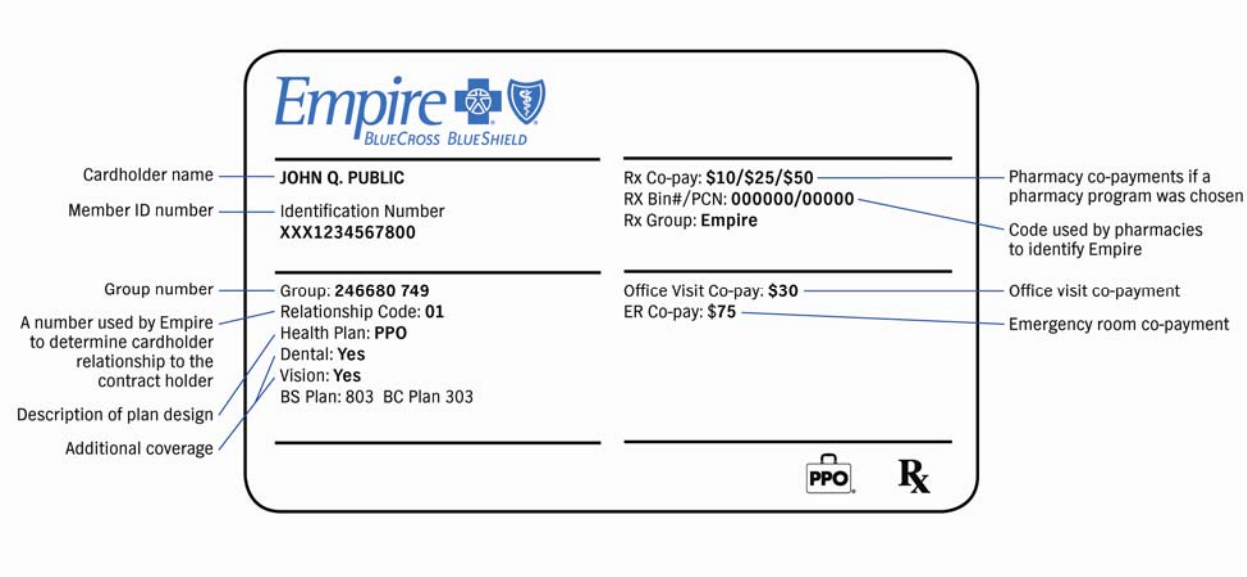
WHAT	WHY	WHERE
MEMBER SERVICES	For questions about your benefits, claims or membership	**1-800-342-9816** TDD for hearing impaired: **1-800-682-8786** 8:30 a.m. to 5:00 p.m. Monday – Friday
ATT SERVICIOS PARA IDIOMAS EXTRANJEROS	Si usted no habla inglés	**1-800-342-9816** Por favor permanezca en la línea y espere que la grabación termine. Un representante de servicios a los miembros contestará la línea y le conectará con un traductor 9:00 a.m. a 5:00 p.m. de Lunes – Viernes
BLUECARD® PPO PROGRAM	Get network benefits while you are away from home Locate a PPO provider outside Empire's network service area	**1-800-810-BLUE (2583)** *www.bcbs.com* 24 hours a day, 7 days a week
MEDICAL MANAGEMENT PROGRAM	Precertification of hospital admissions and certain treatments and procedures.	**1-800-982-8089** 8:30 a.m. to 5:00 p.m. Monday – Friday
24/7 NURSELINE AND AUDIOHEALTH LIBRARY	Speak with a specially trained nurse to get health information and instructions on how to listen to the tapes	**1-877-TALK-2RN (825-5276)** 24 hours a day, 7 days a week
EMPIRE PHARMACY MANAGEMENT PROGRAM	Information about the program Locate a participating retail pharmacy Obtain a complete drug formulary list	**1-800-342-9816** TDD for hearing impaired: **1-800-241-6895** 7:00 a.m. to 10:00 p.m. Monday –- Friday 9:00 a.m. to 9:00 p.m. Saturday 9:00 a.m. to 5:30 p.m. Sunday
VISION CARE	To find a participating Davis vision network provider in your area	**1-877-923-2847** 8:00 a.m. to 8:00 p.m. Monday –- Friday 9:00 a.m. to 4:00 p.m. Saturday
FRAUD HOTLINE	Help prevent health insurance fraud	**1-800-I-C-FRAUD (423-7283)** 9:00 a.m. to 5:00 p.m. Monday – Friday

IN WRITING

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

Your Identification Card

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



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

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

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

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

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

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

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

Using Your PPO

Know the Basics

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

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

CHOOSING IN-NETWORK OR OUT-OF-NETWORK SERVICES

In-network services are health care services provided to a member by a doctor, hospital or healthcare facility in Empire's provider network or in the network of another BlueCross and/or BlueShield plan that participates in the BlueCard PPO Program. When you choose in-network care, you get these advantages:

- CHOICE – You can choose any participating provider from the largest network of doctors and hospitals in New York State or the network of Blue Cross and Blue Shield plans through the BlueCard® PPO Program.
- FREEDOM – You do not need a referral to see a specialist, so you direct your care.
- LOW COST – Benefits are paid after a small co-payment for office visits and many other services.
- BROAD COVERAGE – Benefits are available for a broad range of healthcare services, including visits to specialists, physical therapy, and home health care.
- CONVENIENCE – Usually, there are no claim forms to file.
- Out-of-network services are healthcare services provided by a licensed provider outside Empire's PPO network or the BlueCard PPO networks of other Blue Cross and/or Blue Shield plans. For most services, you can choose in-network or out-of-network. However, some services are only available in-network. When you use out-of-network services:
  - You pay an annual deductible and coinsurance, plus any amount above the allowed amount (the maximum Empire will pay for a covered service) ; if you use a BlueCard provider, you will pay only the lower of billed charges or a negotiated rate and your member liability
  - You will usually have to pay the provider when you receive care
  - You will need to file a claim to be reimbursed by Empire

WHERE TO FIND NETWORK PROVIDERS

Empire's PPO network gives you access to providers within the plan's operating area of 28 eastern New York State counties. See "operating area" in the Details and Definitions section for a listing of counties.

To locate a provider in Empire's operating area, visit ***www.empireblue.com.*** You can search for providers by name, address, language spoken, specialty and hospital affiliation. The search results include a map and directions to the provider's office. Or, ask your Benefits Administrator to see Empire's PPO Directory.

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

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

How to Access Primary and Specialty Care Services

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

To make an appointment call your physician's office:

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

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

When you need care after normal office hours

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

TRANSITIONAL CARE

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

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

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

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

Inter-Plan Programs

Out-of-Area Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Empire's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Empire and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Empire's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other

geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Empire's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Empire's Service Area

Your Liability Calculation

When covered healthcare services are provided outside of Empire's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

BLUECARD® PPO PROGRAM

Care When you are Out of Our Service Area Within the U.S.

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

BLUECARD® WORLDWIDE PROGRAM

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

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

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

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

Your Benefits at a Glance

Empire's plan provides a broad range of benefits to you and your family. Following is a brief overview of your coverage. Some services require precertification with Empire's Medical Management Program. See the Health Management section for details.

	IN-NETWORK	OUT-Of-NETWORK
ANNUAL DEDUCTIBLE*	$0	$500/Individual $1,250/Family
CO-PAYMENT (for office visits and certain covered services)	$30 per visit	N/A
CO-PAYMENT (for hospital inpatient admissions)	$0	N/A
CO-PAYMENT (for emergency room)	$50 per visit (waived if admitted to hospital within 24 hours)	$50 per visit (waived if admitted to hospital within 24 hours)
COINSURANCE	You pay 10% of maximum allowed amount. Plan pays 90% of maximum allowed amount	You pay 30% of maximum allowed amount. Plan pays 70% of maximum allowed amount
ANNUAL OUT-OF-POCKET COINSURANCE MAXIMUM	$250/Individual $625/Family	$1,400/Individual $3,500/Family
LIFETIME MAXIMUM	Unlimited	Unlimited

* *If you had group coverage under a major medical or extended medical plan with Empire prior to your PPO effective date, we will apply any deductible met under that prior contract in the same calendar year to your PPO deductible. For services rendered in October, November or December, deductible credit will be applied to the following year's deductible.*

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
OFFICE VISITS	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
SPECIALIST VISITS	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
CHIROPRACTIC CARE	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
SECOND OR THIRD SURGICAL OPINION**	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
DIABETES EDUCATION AND MANAGEMENT	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
ALLERGY CARE • Office Visit • Testing • Treatment	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance] $0 $0	Deductible and 30% coinsurance
APPLIED BEHAVIOR ANALYSIS (Up to $45,000 maximum per Member per year)	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance

	YOU PAY	
HOME, OFFICE/OUTPATIENT CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
DIAGNOSTIC PROCEDURES • X-rays and other imaging • Radium and Radionuclide therapy • MRIs/MRAs • Nuclear cardiology services • PET/CAT scans • Laboratory tests	10% coinsurance	Deductible and 30% coinsurance
SURGERY	10% coinsurance	Deductible and 30% coinsurance
CHEMOTHERAPY	10% coinsurance	Deductible and 30% coinsurance
X-RAY, RADIUM AND RADIONUCLIDE THERAPY	10% coinsurance	Deductible and 30% coinsurance
SECOND OR THIRD MEDICAL OPINION FOR CANCER DIAGNOSIS***	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
ANNUAL PHYSICAL EXAM • One per calendar year	$0	Not covered
DIAGNOSTIC SCREENING TESTS • Cholesterol: 1 every 2 years (except for triglyceride testing) • Diabetes (if pregnant or considering pregnancy) • Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years • Routine Prostate Specific Antigen (PSA) in asymptomatic males – Over age 50-: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age • Diagnostic PSA: 1 per year	$0 $0 $0 $0 $0	Deductible and 30% coinsurance
WELL-WOMAN CARE • Office visits • Pap smears • Bone Density testing and treatment – Ages 55 through 65 - 1 baseline – Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)* • Mammogram (based on age and medical history) – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year • Women's sterilization procedures and counseling • Breastfeeding support, supplies and counseling – One breast pump per year • Screenings and/or counseling for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections STIs), Human immune deficiency (HIV), interpersonal and domestic violence.	$0 $0 $0 $0 $0 $0	Deductible and 30% coinsurance
WELL-CHILD CARE (covered services and the number of visits are based on the prevailing clinical standards of the American Academy of Pediatrics) • In-hospital visits – Newborn: 2 in-hospital exams at birth – From birth up 1st birthday: 7 visits – Ages 1 through 4 years of age: 7 visits – Ages 5 through 11 years of age: 7 visits – Ages 12 through 17 years of age: 6 visits – Ages 18 to 21st birthday: 2 visits • Lab tests ordered at the well-child visits and performed in the office or in the laboratory Certain immunizations (office visits are not required) **Certain preventive care services are subject to age and frequency limitations.**	$0 $0 $0	Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
EMERGENCY CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
EMERGENCY ROOM	$50 per visit co-payment (waived if admitted to the same hospital within 24 hours)	
PHYSICIAN'S OFFICE	$30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
EMERGENCY AIR AMBULANCE • Transportation to nearest acute care hospital for emergency inpatient admissions	10% coinsurance	You pay the difference between the maximum allowed amount and the total charge.
EMERGENCY LAND AMBULANCE • Local professional ground ambulance to nearest hospital	$0 up to the maximum allowed amount	Subject to in-network benefits
MATERNITY CARE AND REPRODUCTIVE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
PRENATAL AND POSTNATAL CARE (In doctor's office)	10% coinsurance	Deductible and 30% coinsurance
LAB TESTS, SONOGRAMS AND OTHER DIAGNOSTIC PROCEDURES	10% coinsurance	Deductible and 30% coinsurance
ROUTINE NEWBORN NURSERY CARE (In hospital)	10% coinsurance	Deductible and 30% coinsurance
OBSTETRICAL CARE (In hospital)	10% coinsurance	Deductible and 30% coinsurance
ADVANCED REPRODUCTIVE TECHNOLOGIES	10% coinsurance	Not covered
INFERTILITY TREATMENT	10% coinsurance	Deductible and 30% coinsurance
OBSTETRICAL CARE (In birthing center)	10% coinsurance	Not covered

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
HOSPITAL SERVICES[1]	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
ANESTHESIA AND OXYGEN	10% coinsurance	Deductible and 30% coinsurance
BLOOD WORK	10% coinsurance	Deductible and 30% coinsurance
CARDIAC REHABILITATION	$30 co-payment per outpatient visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance
CHEMOTHERAPY AND RADIATION THERAPY	10% coinsurance	Deductible and 30% coinsurance
DIAGNOSTIC X-RAYS AND LAB TESTS	10% coinsurance	Deductible and 30% coinsurance
DRUGS AND DRESSINGS	10% coinsurance	Deductible and 30% coinsurance
GENERAL, SPECIAL AND CRITICAL NURSING CARE	10% coinsurance	Deductible and 30% coinsurance
INTENSIVE CARE	10% coinsurance	Deductible and 30% coinsurance
KIDNEY DIALYSIS	10% coinsurance	Deductible and 30% coinsurance
PRE-SURGICAL TESTING	10% coinsurance	Deductible and 30% coinsurance
SEMI-PRIVATE ROOM AND BOARD	10% coinsurance	Deductible and 30% coinsurance
SERVICES OF LICENSED PHYSICIANS AND SURGEONS	10% coinsurance	Deductible and 30% coinsurance
SURGERY (Inpatient and Outpatient) **	10% coinsurance	Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

[1] *Does not include inpatient or outpatient behavioral healthcare or physical therapy/rehabilitation. Residential treatment services are not covered.*

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

	YOU PAY	
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
DURABLE MEDICAL EQUIPMENT (i.e. hospital-type bed, wheelchair, sleep apnea monitor)	10% coinsurance	Not covered
ORTHOTICS	10% coinsurance	Not covered
PROSTHETICS (i.e. artificial arms, legs, eyes, ears)	10% coinsurance	Not covered
MEDICAL SUPPLIES (i.e. catheters, oxygen, syringes)	10% coinsurance	Difference between the maximum allowed amount and the total charge (deductible and coinsurance do not apply)
NUTRITIONAL SUPPLEMENTS (enteral formulas and modified solid food products)	10% coinsurance	Deductible and 30% coinsurance
ASSISTIVE COMMUNICATION DEVICES (for the treatment of Autism Spectrum Disorder)	10% coinsurance	Deductible and 30% coinsurance
SKILLED NURSING AND HOSPICE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
SKILLED NURSING FACILITY Up to 365 days per calendar year	10% coinsurance	Not covered
HOSPICE Up to 210 days per lifetime	10% coinsurance	Not covered

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
HOME HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
HOME HEALTH CARE Up to 365 visits per calendar year (a visit equals 4 hours of care) **	10% coinsurance	30% coinsurance only. No deductible
HOME INFUSION THERAPY	10% coinsurance	Not covered
PHYSICAL, OCCUPATIONAL, SPEECH OR VISION THERAPY	**IN-NETWORK**	**OUT-OF-NETWORK**
PHYSICAL THERAPY AND REHABILITATION • Unlimited days of inpatient service per calendar year • Unlimited home, office or outpatient facility per calendar year	10% coinsurance $30 co-pay per visit home or office [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance Not covered
OCCUPATIONAL, SPEECH, VISION THERAPY ** • Up to 30 visits per person combined home, office or outpatient facility per calendar year	10% coinsurance $30 co-pay per visit home or office [For examinations, evaluations and consultations; all other services require coinsurance]	Not covered Not covered

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

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

	YOU PAY	
MENTAL HEALTH CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The in-network medical co-payment will apply to examination, evaluation & consultation services; coinsurance will be applied to all other services received during the office visit, with the exception of Well-Child Care, , & Allergy Care.		
OUTPATIENT • Unlimited number of medically necessary visits	**Outpatient Facility** $0 **Outpatient Office** $30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance]	Deductible and 30% coinsurance Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days • Unlimited number of medically necessary visits from mental healthcare professionals	10% coinsurance 10% coinsurance	Deductible and 30% coinsurance Deductible and 30% coinsurance
ALCOHOL OR SUBSTANCE ABUSE TREATMENT	**IN-NETWORK**	**OUT-Of-NETWORK**
OUTPATIENT • Unlimited number of medically necessary visits, including visits for family counseling	**Outpatient Facility** $0 **Outpatient Office** $30 co-payment per visit [For examinations, evaluations and consultations; all other services require coinsurance] t	Deductible and 30% coinsurance Deductible and 30% coinsurance
INPATIENT • Unlimited number of medically necessary days of detoxification • Unlimited number of medically necessary rehabilitation days	10% coinsurance 10% coinsurance	Deductible and 30% coinsurance Deductible and 30% coinsurance

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

	YOU PAY	
PHARMACY (RETAIL AND MAIL ORDER)	**IN-NETWORK**	**OUT-Of-NETWORK**
RETAIL • Card Program An annual deductible of $50 per individual must be paid before Empire will pay benefits for your prescription.	$10 co-payment for generic; ancillary charge for brand $20 co-payment plus ancillary charge for multi-source brand $40 co-payment for single source brand	Not covered
• Mail Order · An annual deductible of $50 per individual must be paid before Empire will pay benefits for your prescription.	$10 co-payment generic for 90 day supply $20 co-payment plus ancillary charge for multi-source brand for 90 day supply $40 co-payment for single source brand for 90 day supply.	Not covered
Generic and Single-Source Brand Name Oral Contraceptive Drugs and Contraceptive Devices	$0 cost share	Not covered
(All of the prescription drug options listed above meet the Centers for Medicare and Medicaid Services (CMS) standards for Medicare prescription drug coverage and each option is considered Creditable Coverage under the Medicare Modernization Act of 2003.)		

[2]*Refer to managed drug requirements on pages 20 and 21*

Please refer to the Health Management section, and your certificate or contract, for details regarding precertification requirements.

VISION[4]	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM (Only available through a Davis Vision network provider) • One eye exam every 24 months **FRAMES** (limited selection)	$5 copay per visit $10 copay per pair $35 allowance for non plan frames	Not covered
LENSES (single vision, bifocal or trifocal)	$0 copay per pair	Not covered
SOFT CONTACT LENSES	$25 copay per pair	Not covered
NON-PLAN SOFT CONTACT LENSES	$75 allowance	Not covered

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

Coverage

Emergency Care

IF YOU NEED EMERGENCY CARE

Should you need emergency care, your plan is there to cover you. Emergency care is covered in the hospital emergency room.

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

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

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

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

4. Serious disfigurement of such person.

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

Emergency Services are not subject to prior authorization requirements.

Sometimes you have a need for medical care that is not an emergency (i.e., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call 24/7 NurseLine at 1-877-TALK2RN (825-5276) for advice, 24 hours a day, seven days a week.

Emergency Assistance 911

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in Empire's PPO network or the PPO network of another Blue Cross and/or Blue Shield plan.

You pay only a co-payment for a visit to an emergency room. This co-payment is waived if you are admitted to the hospital within 24 hours. If you make an emergency visit to your doctor's office, you pay the same co-payment as for an office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. A participating provider must provide all follow-up care in order to receive maximum benefits.

Remember: You will need to show your Empire BlueCross BlueShield I.D. card when you arrive at the emergency room.

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

Future Moms Program

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

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

Please let us know as soon as you know that you're pregnant, so that you will get the appropriate help. A complimentary book on prenatal care is waiting for you when you enroll in the Future Moms Program. Call 1-800-845-4742 and listen for the prompt that says "precertify." You will be transferred to the Future Moms Program. For more information you may also visit us online at *www.empireblue.com*.

Empire's Pharmacy Program

YOUR PHARMACY BENEFITS PROGRAM

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

FILLING A PRESCRIPTION

Empire understands that filling prescriptions can be costly. Therefore, Empire offers the Pharmacy Benefits Management program, to help reduce your costs. Your Empire pharmacy benefits program covers many drugs that have been approved by the Food and Drug Administration (FDA) if the drugs are medically necessary for the treatment of the condition, and you have a prescription from your physician or other licensed provider.

To receive the benefits of your pharmacy program, you must fill your prescription at a network pharmacy or through the mail-order program. To view or print a prescription drug mail order form go to **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Discounts and Savings.

You pay a co-payment or a co-payment plus an ancillary charge each time you fill your prescription at a network pharmacy. An ancillary charge is the price difference between the generic drug's allowed amount and the brand-name drug's price. Your out-of-pocket costs vary depending on whether the prescription is for a generic or brand-name drug. Using generic medicines, where appropriate, will help you to maximize your benefits.

EMPIRE'S DRUG FORMULARY

Empire's Drug Formulary is a list of covered prescription drugs recommended for use by Empire's Pharmacy and Therapeutics (P&T) Committee; composed of clinical pharmacists and independent physicians from various medical specialties. Empire's P&T Committee frequently review new and existing medications based on safety and how well they work, to ensure we meet the needs of our members and to include the newest medications as they become available. Empire's formulary includes generic and certain covered brand-name drugs.

One way we help you and your doctor choose prescription drugs that are clinically appropriate and cost effective is through the step therapy process. The P&T Committee reviews drugs for their safety, effectiveness and value. Based on their findings, the P&T Committee has recommended certain drugs as the first ones to try when starting or changing medication treatment. Trying drugs in this step-by-step fashion is called step therapy.

The use of the formulary is voluntary under your benefits program however you can obtain an up-to-date formulary by visiting **www.empireblue.com** or by calling your pharmacy benefit member service center at 1-800-839-8442.

PRIOR AUTHORIZATION

Certain prescription drugs require prior authorization review before filling. These drugs are identified on the formulary list as "PAR" (Prior Authorization Required) and must be approved by Empire before you fill the prescription. In some instances use of one or more drugs in a step-wise graduated manner for cost/quality reasons may be required first. You can view an up-to-date "PAR" drug listing by visiting **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Drug Information or by calling Member Services at the telephone number listed on your card. Your physician or pharmacist can request this authorization by calling Empire Pharmacy Services at 1-800-839-8442.

QUANTITY LIMITS

Some drugs have quantity limits. They are indicated by the letters "QL" (Quantity Limit) and require authorization only if a prescription is written for more than the monthly allowed amount. You can view quantity limits by going to **www.empireblue.com**, Plans & Benefits, Pharmacy, then go to Drug Information. Some of the drugs requiring any of these actions are noted on the formulary list. If the quantity is approved, it will be covered.

REMEMBER	**Benefits are available for prescriptions filled at network pharmacies.**

NETWORK PHARMACY

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

- **Low cost**. You can receive up to a 30-day supply for each drug for a single co-payment.
- **Convenience**. You must present your Empire ID card to the pharmacist along with your prescription. That's all you need to get the cost advantages of this program.

NON-NETWORK PHARMACY

A non-participating pharmacy is one which does not have an agreement with Empire. You must pay the pharmacy and then you must submit a claim form and receipt to us which verifies that the prescription was filled. We will then pay you the lower of the actual charge of the amount listed in the "Maximum Allowable Cost List", less the co-payment. The "Maximum Allowable Cost List" is a list of prescription drugs that will be covered at a generic product level established by us. This list is subject to periodic review and modified by us. You must pay the difference between our payment and the actual charge. Brand name prescription drugs for which there are no generic equivalents shall be reimbursed at the actual charge, less the co-payment.

Tip for Using a Network Pharmacy

To locate a network pharmacy, check the list of national chain pharmacies you received with your I.D. card. For information about network pharmacies that are not a part of a national chain, log on to ***www.empireblue.com*** and click on the Rx icon on your home page or call Empire Pharmacy Management at 1-800-342-9816. You can also call when you are away from home for the name and location of the nearest participating pharmacy.

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

MAIL ORDER CHRONIC DRUG PROGRAM

If your prescription is filled through our Mail Order Chronic Drug Program, we will pay the entire cost of the prescription or refill for a 90 day supply, after one $10 co-payment for generic, $40 co-payment for single source brand, or $10 co-payment with ancillary charge for multi-source. The chronic drug must require a prescription in order to be dispensed and it must be prescribed by your Doctor. A chronic drug is a drug which is: an antiarthritic; an anticoagulant; a cardiac drug; a hormone; a thyroid preparation; insulin; or any other drug we place on a list of chronic drugs available under this section.

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

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

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

How to Order Your Prescription by Mail

- Ask your doctor to write a prescription for each of your medication(s)
- Complete the mail order form you received in the mail with your ID card(s). You can get additional forms by going to ***www.empireblue.com*** or calling Empire Pharmacy Management at the number on the back of your member ID card.
- Place your order for a refill at least three weeks before your current supply will run out.
- You will receive your filled prescription at your home within 14 working days, postage paid. If you prefer, you can also choose faster shipping for an additional fee

Tips for Using Mail Order

- The first time you fill a prescription through mail order, ask your physician for a second prescription for a three-week supply. You can fill the second prescription at a local pharmacy so you have the medication until the mail order is processed.
- Place your order for a refill at least three weeks before your current supply will run out.

MANAGE YOUR PHARMACY PLAN ONLINE

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

- Search Empire's drug formulary for a particular drug (by name or therapeutic category)
- Locate a participating retail pharmacy near where you live or work
- Order prescription refills through the mail order program
- Research usage instructions, drug interactions and side effects for thousands of medications
- Simply log on to our website and access your own personal secure home page. Click on "My Pharmacy Plan" which is right next to the Rx symbol under "Your Health Plan."

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

Vision Care

IF YOU NEED VISION CARE

Empire recognizes that good vision is part of good health, so we offer vision care coverage. You receive vision care benefits only when you use network providers. To find a participating provider in your area, simply call 1-877-923-2847 between 8:00 a.m. and 8:00 p.m. weekdays, 9:00 a.m. and 4:00 p.m. Saturdays. Then contact the provider to make an appointment. Benefits are paid in full when you use a network provider, subject to the co-payments shown below.

VISION CARE SERVICES	CO-PAYMENT
EYE EXAM	$5
FRAMES (limited selection)*	$10
PREMIER FRAMES	$10
SOFT CONTACT LENSES – PER PAIR (STANDARD DAILY WEAR)**	$10
SINGLE VISION, BIFOCAL OR TRIFOCAL LENSES	$0
STANDARD PROGRESSIVE ADDITIONAL LENSES	$50
BLENDED SEGMENT LENSES	$20
PHOTOCHROMIC OR SUPERSHIELD SINGLE VISION LENSES	$20
PHOTOCHROMIC OR SUPERSHIELD MULTIFOCAL VISION LENSES	$20
ULTRAVIOLET COATING	$12
REFLECTION-FREE COATING	$35
POLAROID LENSES	$75
POLYCARBONATE LENSES	$30
HIGH INDEX LENSES	$55
TRANSITION LENSES	$65

What's Covered

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

What's Not Covered

The following vision care services are not covered:

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

*In addition, vision care benefits include a $35 allowance for non-plan frames.

** In addition, vision care benefits include a $75 allowance for non-plan soft contact lenses.

Health Management

Empire's Medical Management Program

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

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

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

How Empire's Medical Management Program Helps You

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

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

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

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

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

IF SERVICES ARE NOT PRECERTIFIED

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

INITIAL DECISIONS

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

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

- ***Retrospective Requests*.** Retrospective review is conducted after you receive medical services. We will complete all retrospective reviews of services already provided within 30 calendar days of our receipt of the claim. If we do not have enough information to make a decision within 30 calendar days, a clinical denial of coverage is rendered. The letter you receive will tell you how to appeal the denial of coverage decision. If Empire's Medical Management Program does not meet the above time frames, the failure should be considered a denial. You or your doctor may immediately appeal.

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

IF A REQUEST IS DENIED

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

If Empire's Medical Management Program denies benefits for care or services without discussing the decision with your doctor, your doctor is entitled to ask Medical Management to reconsider their decision. A response will be provided by telephone and in writing within one business day of making the decision.

Preventive Services

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

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

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

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

   Examples of these services are screenings for:

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

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

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

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

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

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

     For individuals who are:
     - Ages 52 through 65 - 1 baseline
     - Age 65 and older - 1 every 2 years (if baseline before age 65 does not indicate osteoporosis)

– Under Age 65 - 1 every 2 years (if baseline before age 65 indicates osteoporosis)

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

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

- Well-woman care visits to a gynecologist/obstetrician

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

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

  In addition, coverage is available for generic and single-source brand name prescription drugs for oral contraceptives and patches dispensed from a pharmacy. To obtain benefits, prescription drugs must be approved by the federal Food and Drug Administration and must be obtained from a retail or mail order pharmacy that is a member of our Pharmacy Network. Please see the Oral Contraceptive Prescription Drug Rider for more information.

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

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

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

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

360° Health – Empire's Health Services Programs

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

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

- Online health and wellness resources.
- Discounts on health-related products & services, and alternative therapies
- Guidance and support for when you need help
- Condition management for those with chronic health issues. The following are descriptions of some of the programs and services available to you:

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

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

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

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

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

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

Here's how to use 24/7 NurseLine:

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

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

Alternative Practitioners – Receive discounts on services from hundreds of chiropractors, acupuncturists, massage therapists and nutritional counselors participating in alternative healthcare programs administered by American Specialty Health Networks™ (ASH Networks) — all without a doctor's referral. Access ASH Network's online directory by clicking on the Healthyroads link on the *Empire Healthy Discounts* web page. You can then show your member ID during your office visit to quality for the discount.

Wellness Products – Members receive discounts of up to 40% on thousands of quality health and wellness products: vitamins, herbal supplements, homeopathic remedies, sports nutrition products, health-related books and videos and more. You may purchase products by clicking on the Healthyroads link on the *Empire Healthy Discounts* web page or by calling 1-888-289-4325.

Fitness Club Membership – Save on membership fees and receive a free one-week membership with any of the thousands of facilities with **Healthyroads**. You can even get discounts on home fitness equipment. To find a club near you and printout savings certificates, click on the Healthyroads link on the *Empire Healthy Discounts* web page or call 1-877-335-2746.

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

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

* Participating Weight Watchers include locations in Empire's operating area in New York (except Suffolk County) or New Jersey (except Camden and Burlington Counties).

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

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

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

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

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

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

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

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

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

Details and Definitions

In this section, we'll cover the details you need to know to make the plan work for you. Use it as a reference. Knowing the details can make a difference in how satisfied you are with your plan, and how easy it is for you to use. If you have additional questions, please visit *www.empireblue.com* or call Member Services at 1-800-342-9816.

Qualified Medical Child Support Orders (QMCSO)

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

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

A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not the group health plan participant.

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

Women's Health and Cancer Rights of Act 1998

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

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

Claims

IF YOU NEED TO FILE A CLAIM

Empire makes healthcare easy by paying providers directly when you stay in-network. Therefore, when you receive care from providers or facilities in the Empire or BlueCard PPO networks, you generally do not have to file a claim. However, you will have to file a claim for reimbursement for covered services received out-of-network, from a non-participating provider, or if you have a medical emergency out of the Empire service area. To obtain a claim form, call customer service or visit our website www.empireblue.com.

TYPE OF CLAIM	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	Provider files claim with Empire or local Blue Cross/Blue Shield plan*
MEDICAL	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire
AMBULANCE CHARGES	Provider files claim directly with Empire or local Blue Cross/Blue Shield plan	You file claim with Empire

- At some out-of-area and non-participating hospitals, you may have to pay the hospital's bill. If this happens, include an original itemized hospital bill with your claim.

Send completed forms to:

Hospital Claims:

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

Medical Claims:

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

Want more claim information? Now you can check the status of a claim, view and print Explanation of Benefits (EOB), correct certain claim information and more at any time of day or night just by visiting *www.empireblue.com*.

Out-of-Network Claims for Chiropractic Care

If you use an Out-of-Network chiropractic provider for chiropractic care, you will need to complete a claim form for the out-of-network services, and mail it directly to:

American Specialty Health Networks
PO Box 509001
San Diego, CA 92150-9001

Tips for Filing a Claim

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

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

Reimbursement For Covered Services

Maximum Allowed Amount

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

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

Providers who have not signed any contract with Us and are not in any of our networks are Out-of-Network Providers.

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

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

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

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

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

MEMBER COST SHARE

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

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

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

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

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

Example: Your Plan has Coinsurance of 20% for In-Network services, and 30% Out-of-Network after the In- or Out-of-Network Deductible has been met. You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

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

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

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

AUTHORIZED SERVICES

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network cost share amounts (Deductible, Copayment and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize an Out-of-Network Covered Service so that you are responsible for the In-Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for information or to request authorization.

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

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

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

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

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

Complaints, Appeals and Grievances

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

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

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

STANDARD LEVEL 1 APPEALS

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

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

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

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

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

In addition, if the groups is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Group members have certain rights and protections and the group may have duties as the Group Health Plan Administrator. Among them is the right to appeal a claim decision. Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 180 days to appeal our decision.

The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty (60) days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed one-hundred, twenty (120) days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

EXPEDITED LEVEL 1 APPEALS

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

i. Continuations or extensions of health care services, procedures or treatments already begun;
ii. Additional required or provided care during an ongoing course of treatment; or
iii. A case in which the Provider believes an expedited appeal is justified because delay in treatment would pose an imminent or serious threat to the Covered Person's health or ability to regain maximum function, or would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

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

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

STANDARD LEVEL 2 APPEALS

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

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

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

HOW TO REQUEST AN APPEAL

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

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

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

EXTERNAL APPEALS

Your Right to an External Appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination That a Service is not Medically Necessary

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

- The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract; and

- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered);or

- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

The External Appeal Process

If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

Your Responsibilities

It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

Covered Services/Exclusions

In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with the subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

We will not provide coverage for any service that is not a Covered Service under the Contract. All other terms of your Contract apply to this Section, including any applicable co-payments, Coinsurance or Deductibles.

COMPLAINTS

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

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

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

We will resolve complaints within the following time frames:

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

LEVEL 1 GRIEVANCE

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

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

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

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

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

LEVEL 2 GRIEVANCES

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

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

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

EXPEDITED GRIEVANCES

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

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

- Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within seventy-two (72) hours of receipt of the grievance.
- Empire will notify you immediately of the decision by telephone, and within two (2) business days in writing.

DECISION ON GRIEVANCES

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

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

HOW TO FILE A GRIEVANCE

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

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

Send appeals concerning behavioral health care to:

Empire Behavioral Health Services
370 Bassett Road
Building 4, Floor 2
North Haven, CT 06473

HOW YOU CAN PARTICIPATE IN POLICY DEVELOPMENT

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

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

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

PROVIDER QUALITY ASSURANCE

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

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

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

Ending and Continuing Coverage

WHEN COVERAGE ENDS

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

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

IMPORTANT INFORMATION

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

WHAT IS CONTINUATION COVERAGE?

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

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

Notice of Qualifying Events:

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

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

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

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

HOW CAN YOU EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

DISABILITY

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

SECOND QUALIFYING EVENT

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

HOW CAN YOU ELECT COBRA CONTINUATION COVERAGE?

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

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

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

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

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

FOR MORE INFORMATION

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

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Group Benefit Administrator at your employer.

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

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

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

CONTINUING COVERAGE UNDER NEW YORK STATE LAW

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

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

THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

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

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

RESERVISTS SUPPLEMENTARY CONTINUATION AND CONVERSION

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

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

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

CONVERTING YOUR COVERAGE

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

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

- You, your spouse or dependent child no longer qualifies as a family member under the contract because:
- Your child no longer qualifies as a covered dependent
- Your covered incapacitated child no longer qualifies as incapacitated
- Your spouse divorces or annuls your marriage
- You die

- You no longer qualify as a group member
- Your company no longer meets our underwriting standards
- Your company terminates the contract and does not offer replacement coverage to group members
- You are a member or the spouse of a member and have elected Medicare as your primary coverage

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

To convert your coverage, you must:

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

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

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

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

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

ENDING AND CONTINUING COVERAGE

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

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

PORTABILITY OF COVERAGE

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

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

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

IF YOU BECOME DISABLED

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

Coverage will end when the disabled person:

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

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

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

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

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

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

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

CARVE-OUT PROGRAM

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

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

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

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

Your ERISA Rights

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

THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

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

Duties of the Plan Fiduciaries

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

Steps You Can Take to Enforce Your Rights

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

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

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

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

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

ACCESS TO INFORMATION

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

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

For Members Who Don't Speak English

Empire will help members who speak languages other than English ask questions and file grievances in their first language. When you call Member Services, the operator will link you to an interpreter in your preferred language, who can facilitate the discussion. 24/7 NurseLine is also equipped to provide assistance in most languages.

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

HIPAA Notice of Privacy Practices

Effective July 1, 2007

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

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

Your Protected Health Information

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

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

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

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

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

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

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

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

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

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.

- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.

- Send us a written request to ask us for a list of certain disclosures of your PHI.

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

How we protect information

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

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

Potential Impact of Other Applicable Laws

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

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

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

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

STATE NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

You have the right to access and correct your PI.

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

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

AudioHealth Library Topics

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

Abdominal Problems

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

Allergies

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

Back and Neck Pain

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

Bone, Muscle and Joint Problems

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

Cancer

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

Chest, Respiratory and Circulatory Problems

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

Chronic Conditions

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

Ear, Nose and Throat

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

Eye Problems

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

First Aid and Emergencies

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

Headaches and Nervous System Problems

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

Home Health Medicines and Supplies

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

Infant and Child Health

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

Infant and Child Health

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

Infectious Diseases

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

Living Healthy

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

Medical Tests and Procedures

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

Men's Health

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

Mental Health Problems and Mind-Body Wellness

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

Partnership with your doctor

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

Senior Health

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

Skin Problems

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

Sleeping Disorders

2400 Sleep Problems
2403 Sleep Apnea
2406 Snoring

Women's Health

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

Women’s Health

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

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

This is Your

EMPIRE HEALTHCHOICE, INC.
PREFERRED PROVIDER ORGANIZATION (PPO)
GROUP CONTRACT PROVIDING
HOSPITAL AND EXTENDED MEDICAL BENEFITS

Issued By

EMPIRE HEALTHCHOICE, INC.

Group Name:	Dutchess Educational Health Insurance Consortium (**DEHIC) Healthy Advantage PPO Plan**
Group Number(s):	980925
Effective Date:	November 1, 2013

In consideration of your payment to us of the full premiums we accept your application, and agree to provide the benefits described in this Contract beginning at 12:01 a.m., standard time, New York, N.Y., on the "Effective Date," as set forth in the Group Application, for a period of twelve months until this Contract is terminated pursuant to Article XV. Premiums must be paid on or before the Effective Date for this Contract to take effect and thereafter as described in Article I, Section H of this Contract.

This Contract is between you (the Group) and Empire HealthChoice, Inc. If a copy of this contract is given to the Member it will serve as a Certificate of Coverage.

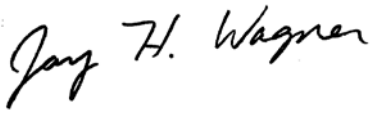
IMPORTANT NOTICE

This Contract describes hospital and extended medical benefits for the Empire HealthChoice, Inc. Preferred Provider Organization (PPO). Each person covered under this contract must satisfy the In-Network copayments as set forth in the Schedule of Benefits. The Covered Person may elect to receive covered benefits from an Out-of-Network Provider. Out-of-Network benefits are subject to the Out-of-Network deductible and coinsurance amounts set forth in the Schedule of Benefits. Not all benefits are available on an Out-of-Network basis.

The use of out-of-network providers may result in substantial out-of-pocket expenses. The out-of-network Allowed Amount is not intended to reflect a provider's charge. That Allowed Amount may be substantially less than the provider's charge.

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.

IN WITNESS WHEREOF, Empire HealthChoice, Inc. has caused this Contract to be executed at New York, New York.



Jay H. Wagner
Corporate Secretary

Mark Wagar
President

CR-GR-PPO.A/Rev.99

LGL 4704 (01/12)

SCHEDULE OF BENEFITS
FOR EMPIRE HEALTHCHOICE ASSURANCE, INC.
LARGE GROUP PPO CONTRACT

Dutchess Educational Health Insurance Consortium
(DEHIC) Healthy Advantage PPO Plan
Group Number(s): 980925
Effective November 1, 2013

1.	Age Limits	End of Calendar Month
	Dependent Children	26
	Full-time Students	26
	IN-NETWORK COST SHARING REQUIREMENTS	
2.	Calendar Year Deductible	
	Individual	$0
	Family	$0
3.	Coinsurance	*
4.	Annual Out-of-Pocket Coinsurance Maximum	
	Individual	*
	Family	*
5.	In-Network Copayments	
	a. Home/Office Visits	$30
	b. Annual Physicals	$0
	c. Well Woman Exams	$0
	d. Therapies: Outpatient Physical, Occupational, Speech, Vision	$30
	e. Consultations	$30
	f. Office/Outpatient Mental Health Visit	See Mental Health and Substance Abuse Schedule of Benefits
	g. Inpatient Hospital and Facility Admission	Coinsurance
	Annual Out-of-Pocket Copayment Maximum	Coinsurance
6.	Emergency Room Visit Copayment	$50

***A non-standard amount has been requested. Refer to the attached MEMO for details.**

SCHEDULE OF BENEFITS
FOR EMPIRE HEALTHCHOICE ASSURANCE, INC.
LARGE GROUP PPO CONTRACT

Dutchess Educational Health Insurance Consortium
(DEHIC) Healthy Advantage PPO Plan
Group Number(s): 980925
Effective November 1, 2013

OUT-OF-NETWORK COST SHARING REQUIREMENTS

7.	Calendar Year Deductible	
	Individual	*
	Family	*
8.	Coinsurance	*
9.	Annual Out-of-Pocket Coinsurance Maximum	
	Individual	*
	Family	*
10.	Out-of-Network Lifetime Benefit Maximum	Unlimited

DAY/VISIT LIMITS PER PERSON, PER CALENDAR YEAR

11.	Physical Therapy Visits, any combination – Home, Office or Outpatient Department	*
12.	Occupational/Speech/Vision Therapies Visits, any combination – Home, Office, Outpatient Department	30
13.	Outpatient Mental Health Visits	See Mental Health and Substance Abuse Schedule of Benefits
14.	Skilled Nursing Facility Care Days In-Network Only	365 Days
15.	Inpatient Physical Therapy Days, Including Professional Charges	*
16.	Inpatient Mental Health Days	See Mental Health and Substance Abuse Schedule of Benefits
17.	Home Health Care	*

***A non-standard amount has been requested. Refer to the attached MEMO for details.**

EMPIRE HEALTHCHOICE ASSURANCE, INC.
MENTAL HEALTH AND SUBSTANCE ABUSE
SCHEDULE OF BENEFITS
IN-NETWORK

MENTAL HEALTH CARE	
Outpatient	Office Visit Copayment, applies to office visits (examinations and evaluations). All other Covered Services rendered during visit are subject to Coinsurance
Visit maximum, any combination – home, office, outpatient department	Unlimited (Combined, In- and Out-of-Network)
Inpatient	Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)
ALCOHOL/SUBSTANCE ABUSE TREATMENT	
Outpatient	Office Visit Copayment, applies to office visits (examinations and evaluations). All other Covered Services rendered during visit are subject to Coinsurance
Visit maximum, any combination – home, office, outpatient department	Unlimited (Combined, In- and Out-of-Network)
Inpatient Detoxification	Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)
Inpatient Rehabilitation	Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)

EMPIRE HEALTHCHOICE ASSURANCE, INC.
MENTAL HEALTH AND SUBSTANCE ABUSE
SCHEDULE OF BENEFITS
OUT-OF-NETWORK

MENTAL HEALTH CARE	
Outpatient	Deductible and Coinsurance
Visit maximum, any combination – home, office, outpatient department	Unlimited (Combined, In- and Out-of-Network)
Inpatient	Deductible and Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)
ALCOHOL/SUBSTANCE ABUSE TREATMENT	
Outpatient	Deductible and Coinsurance
Visit maximum, any combination – home, office, outpatient department	Unlimited (Combined, In- and Out-of-Network)
Inpatient Detoxification	Deductible and Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)
Inpatient Rehabilitation	Deductible and Coinsurance
Day maximum, 2 partial hospitalization visits equal one inpatient day	Unlimited (Combined, In- and Out-of-Network)

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO BENEFIT CONTRACT

GROUP NAME: **Dutchess Educational Health Insurance Consortium (DEHIC)**
GROUP NUMBER: **980925**
EFFECTIVE DATE: **July 1, 2013**
PLAN NAME: **Preferred Provider Organization (PPO) Healthy Advantage Plan**

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

COST-SHARING AMOUNTS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual	$0	$500
Family	$0	$1,250
Coinsurance (Member responsibility)	10%	30%
Annual Coinsurance Maximum (excluding Annual Deductible)		
Individual	$250	$900
Family	$625	$2,250
Annual Total Out-of-Pocket Maximum (includes Annual Deductible)		
Individual	$250	$1,400
Family	$625	$3,500
SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Physical Therapy (unlimited visits, combined In- and Out-of-Network)		Not Covered
Examinations, evaluations, consultations	Office Visit Copayment	
Other covered services rendered during office visit	Coinsurance	
Inpatient Physical Therapy (unlimited days, combined In- and Out-of-Network)	Coinsurance	Deductible & Coinsurance
Home Health Care (365 days per year, combined In- and Out-of-Network)	Coinsurance	Coinsurance

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

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

EMPIRE HEALTHCHOICE ASSURANCE, INC.

PRESCRIPTION DRUG RIDER
SCHEDULE OF BENEFITS

Annual Deductible	$50 Per Covered Person Per Calendar Year The annual pharmacy deductible is waived for drugs purchased through Empire's mail order program.
Participating Retail Pharmacy	All drugs purchased at a participating retail pharmacy will be subject to one (1) Copayment for each supply of up to 30 days, as shown below, or the cost of the drug, whichever is less:
Category of Drug	Copayment up to 30 day supply, or the cost of the drug, whichever is less
Tier 1	$10
Tier 2	$20
Tier 3	$40
Participating Mail Order Pharmacy	A supply of drugs for up to 30 days can be purchased through Empire's mail order program, as shown below:
Category of Drug	Copayment up to 30 day supply, or the cost of the drug, whichever is less.
Tier 1	$10
Tier 2	$20
Tier 3	$40
Category of Drug	Copayment for 31-90 day supply, or the cost of the drug, whichever is less.
Tier 1	$20
Tier 2	$40
Tier 3	$80

EMPIRE HEALTHCHOICE ASSURANCE, INC.

R-42 VISION
SCHEDULE OF BENEFITS

1. **Vision Benefits**	**Benefit Period**
	Once every 24 months
2. **Services**	**Co-payment**
Eye Exams	$5
Frames	$10
Lenses (One pair)	
Single Vision	$0
Bifocal	$0
Trifocal	$0
Soft Contact Lenses (One pair)	
Standard Daily Wear	$10
Disposables	$10
3. **Optional Services – Additional Co-payments**	
Designer Frames	$0
Premier Frame	$25
Standard Progressive Addition Lenses	$50
Premium Progressive Addition Lenses	$90
Blended Segment Lenses	$20
Photochromic Single Vision Lenses	$20
Photochromic Multifocal Lenses	$20
Supershield Single Vision Lenses	$20
Supershield Multifocal Lenses	$20
Ultraviolet Coating	$12
Reflection-free Coating	$35
Premium Reflection-Free Coating	$48
Polaroid Lenses	$75
Polycarbonate Lenses	$30
High Index Lenses	$55
Transition Lenses	$65
Intermediate Vision Lenses	$30
4. **Nonplan Allowances**	**Allowance**
Davis Vision Nonplan Frame Allowance	$35
Davis Vision Nonplan Contact Lens Allowance	$75
5. **Out-of-Network Benefits**	**Allowance**
Eye Exam	$30
Frames	$30
Lenses (One pair)	
Single Vision	$25
Bifocal	$35
Trifocal	$45
Contact Lens	$75

Empire BlueCross BlueShield

EMPIRE HEALTHCHOICE ASSURANCE, INC.
VISION AID RIDER

1. **Vision Aid Benefits.** Under this Rider you are eligible for a comprehensive eye examination, frames and corrective lenses (eyeglasses or soft contact lenses) once during the period of time listed on the Schedule of Benefits. These services are covered in full, subject to the co-payments described below, at a Vision Network Provider, unless specifically stated otherwise.

2. **How to Obtain Vision Aid Services.** In order for in-network benefits to apply, make an appointment with a Vision Network Provider. If you purchase eyewear, you must buy it from the same Network Provider who did the examination. If you choose eyewear from the standard group of frames, lenses and contact lenses, you pay limited co-payments. You also have the option of purchasing eyewear from an additional selection listed under optional services, and paying the additional co-payments. You may also purchase Nonplan frames or contact lenses from your Davis Vision provider, in which case you will be reimbursed at the allowance amount. Out-of-network benefits can be accessed at any vision provider.

3. **Payments Under This Rider.** Listed on the Schedule of Benefits are the co-payment amounts you pay when you receive services listed below at a Vision Network Provider, or the benefit allowance you are entitled to when you purchase Nonplan frames or contact lenses from your Davis Vision provider, or if you receive covered services at an out-of-network provider.

   Service

   Eye Examination
   Frames
   Lenses* (One pair)
   - Single Vision
   - Bifocal
   - Trifocal

   Soft Contact Lenses (One pair)
   - Standard Daily Wear
   - Disposables

   *Covered lenses include the following: glass or plastic, oversize, cataract eyeglasses, gradient tints, fashion tinting of plastic lenses; glass grey #3 prescription sunglasses.

4. A. **Optional Services.** You have the option of purchasing the following services for an additional co-payment. You must pay the co-payment listed on the Schedule of Benefits in Section 3, in addition to the co-payment listed on the Schedule of Benefits in Section 2.
   Designer Frames
   Premier Frame
   Standard Progressive Addition Lenses
   Premium Progressive Addition Lenses
   Blended Segment Lenses
   Photochromic Single Vision Lenses

Photochromic Multifocal Lenses
Supershield Single Vision Lenses
Supershield Multifocal Lenses
Ultraviolet Coating
Reflection-free Coating
Premium Reflection-Free Coating Polaroid Lenses
Polycarbonate Lenses
High Index Lenses
Transition Lenses
Intermediate Vision lenses

B. **Nonplan Allowances.** If you wish to purchase Nonplan frames or contact lenses from Davis Vision you will be reimbursed at the allowance amount listed in Section 4 of the Schedule of Benefits.

5. **Out-of-Network Benefits.** The following benefits are available from out-of-network providers, and you will be reimbursed at the allowance amount listed in Section 5 of the Schedule of Benefits:

Eye Examination
Frames
Lenses (One pair)
Single Vision
Bifocal
Trifocal
Contact Lenses

6. **Limitations and Exclusions.** The following limitations and exclusions apply to this Rider:
   a. Routine eye exams must be conducted in a single visit.
   b. Treatment of eye disease is not covered under this Rider.
   c. All portions of the benefit (exam, lenses, frames) must be used at the same time.
   d. The following additional exclusions apply to this Rider:
      - Special procedures such as orthoptics training
      - Replacement of lost, stolen, broken or duplicate frames or lenses
      - Eye examinations required by an employer
      - Any procedures or materials not specifically provided by this Rider
      - More than one benefit in the period of time listed on the Schedule of Benefits

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

Seth Truwit
Corporate Secretary

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

EMPIRE HEALTHCHOICE ASSURANCE, INC.

PRESCRIPTION DRUG RIDER

The Contract or Certificate to which this Rider is attached is amended, and any prescription drug coverage is deleted and replaced with the coverage set forth in this Rider. If the Contract to which this Rider is attached has no prescription drug coverage, then the Article entitled "Medical Benefits" is amended to add coverage for prescription drugs as set forth in this Rider:

1. **Prescription Drug Benefits.** We will pay for those drugs approved by the Food and Drug Administration of the United States government (FDA) that require a prescription, are Medically Necessary, and prescribed by a provider legally authorized to prescribe the drug or item under Title Eight (8) of the Education Law. Coverage includes, but is not limited to, the following mandated drugs, devices and supplements (subject to change to conform to future changes that may be made to state and federal law):

   - Insulin and related supplies and equipment for treatment of diabetes
   - Infertility drugs
   - Medically necessary nutritional supplements for the therapeutic treatment of Phenylketonuria, branched-chain ketonuria, galactosemia and homecystinuria when administered under the direction of a Physician.
   - Bone density drugs and devices or generic equivalents approved as substitutes.
   - Medically necessary enteral formulas for which a written order has been issued. The written order must state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific form of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic physical disability, mental retardation, or death, if left untreated. We will also pay for modified solid food products for the treatment of certain inherited diseases of amino acid or organic acid metabolism, when provided pursuant to such a written order.
   - Oral chemotherapy drugs, which will be subject to member cost share that is no more than the cost share amount that applies if provided as a medical benefit.
   - Medically Necessary prescription drugs to treat autism spectrum disorder.

2. **Preferred Drug Formulary.** Empire uses a preferred drug formulary which is a list of generic and preferred brand drugs that is distributed to participating pharmacies and providers and is subject to periodic review and modification by Us. Your doctor is encouraged to prescribe generic-equivalent drugs as appropriate when possible and to prescribe drugs from the preferred drug formulary when prescribing brand-name drugs.

   The Preferred Formulary has three tiers.

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

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

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

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

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

3. Terms of Payment. We will only make payments when the drug is prescribed for your use outside of a hospital. The prescription order must be issued by a provider legally authorized to issue the prescription order. The prescription order must be filled by a licensed pharmacist in an Empire network pharmacy licensed by the state.

We will only make payments at a pharmacy which is a member of our Pharmacy Network. A pharmacy which is a member of our Pharmacy Network is one which has entered into an agreement to provide prescription drug benefits to the persons covered by this Rider. If the prescription is filled outside of our Service Area, the pharmacy must be a member of the National network with which we have an agreement. When you purchase prescription drugs from a retail pharmacy that has agreed to the same terms, conditions and reimbursements as our network mail order pharmacy, we will apply the same cost sharing, day supply and other conditions that apply to prescription drugs you purchase from our mail order pharmacy.

When you have a prescription filled, you must pay the pharmacy the cost share amount for each separate prescription or refill. We will pay the pharmacy directly for the remainder of the cost of the prescription or refill. The Maximum Allowed Amount for covered Prescription Drugs is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

The amount of the cost share for your prescription drug coverage is listed in the attached Prescription Drug Rider Schedule of Benefits. Copayments do not apply to the satisfaction of the Deductible requirements of this Prescription Drug Rider or the Deductible and/or Coinsurance requirements of the Contract or Certificate to which this Prescription Drug Rider is attached.

We will pay for no more than a 30-calendar day supply of the drugs on each occasion when you have the prescription filled or refilled at a participating retail pharmacy. However, prescription orders for maintenance drugs may be dispensed in a 90 consecutive day supply.

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

Whenever you have a prescription filled, you must present your member identification card to the pharmacy in order for the prescription to be covered by this Rider.

4. **Mail Order Prescription Drugs.** We will also pay for those FDA approved, maintenance drugs which require a prescription, through our mail order participating pharmacy. Other drugs may also be purchased at mail order. Mail order prescription drugs may be dispensed up to the day supply listed on the attached Prescription Drug Rider Schedule of Benefits. You will be required to pay the cost share amount indicated on the attached Prescription Drug Rider Schedule of Benefits.

   The maintenance drug list is updated periodically. Call the customer service number on the back of your member identification card to find out if a particular drug is on the maintenance list.

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

   When you have a prescription filled through mail order you must pay the pharmacy the cost share amount for each separate prescription or refill. The days supply and refill restrictions described above also apply to mail order drugs.

5. **Miscellaneous Prescription Drug Plan Provisions**

   a. **Prior Authorization Requirements.** The Prescription Drugs (or the prescribed quantity of a particular drug) listed on Schedule A.1 to this Rider require prior authorization. The Schedule is subject to periodic review and amendment. You may review a list of the current drugs requiring prior authorization by calling Customer Service at the telephone number on the back of your ID card or by going to our website at *www.empireblue.com* and clicking on "Drug Coverage" and "Formulary". Your provider or network pharmacist may also check with us at any time to verify coverage, any quantity limits, Step Therapy, and prior authorization requirements for prescription drugs. Please bear in mind that inclusion of a drug or related item on the Schedules to this Rider is not a guarantee of coverage under your Contract, Certificate or Group Plan.

      Additional prescription drugs or categories of drugs may require prior authorization pursuant to the terms of your Prescription Drug Rider or your Contract, Certificate or Group Plan.

      If you receive a prescription for a drug that requires prior authorization, your pharmacist will contact Empire to request approval.

      If prior authorization is denied, you have the right to appeal through the appeals process outlined in your Contract, Certificate or Group Plan.

   b. **Step Therapy Program.** Step therapy means that a Covered Person may need to use one type of medication, such as a generic drug or a cost-effective alternative to a prescribed drug, before another. The Prescription Drugs listed on Schedule A.2 require prior authorization if a generic drug or cost-effective alternative Prescription Drug has not been tried.

c. Specialty Drugs. You or your Physician are required to order your Specialty Drugs directly from a Network Specialty Pharmacy. "Specialty Drugs" are prescription drugs which:

- Are approved to treat limited patient populations, indications or conditions;
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support any or all of which make the drug difficult to obtain through traditional pharmacies.

i. Network Specialty Pharmacies may fill both retail and mail service Specialty Drug prescription orders, up to a thirty (30) day supply for retail and mail service, and subject to the applicable Deductible, Coinsurance or Copayment shown in the Schedule of Benefits.

ii. Network Specialty Pharmacies have dedicated patient care coordinators to help you obtain prior authorization, if applicable, manage your condition, and offer toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications.

iii. You may obtain a list of the Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on the back of your ID card, or review the lists on our website at www.empireblue.com, select "Pharmacy" under the "Plans and Benefits" tab of the "Member Home" page.

iv. In addition, certain drugs that must be administered by a physician or other authorized practitioner are required to be ordered from our Network Specialty Pharmacy in order to be covered as a medical benefit. If you require one of these drugs, your physician or other treating practitioner will order the drug from the required pharmacy. You will not be required to fill a prescription for this category of drug.

d. Special Programs. From time to time we may initiate various programs to encourage Covered Persons to utilize more cost-effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, over the counter (OTC), or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

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

a. Administration or injection of any drugs.

b. Appetite suppressants will only be covered when prescribed by a physician to treat a medically necessary condition.

c. Replacement resulting from loss, theft or breakage.

d. Devices of any type such as therapeutic devices including diaphragms, IUDs, and Norplant, artificial appliances, hypodermic needles, syringes or similar devices except where specifically covered.

e. Drugs that are considered to be experimental or investigational, as more fully defined in the Contract to which this Rider applies. However, coverage will not be excluded for expenses incurred in prescribing a drug for a treatment for which it has not been approved by the Food and Drug Administration of the United States government for the treatment of certain types of cancer if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established references:

(1) National Comprehensive Cancer Networks Drugs and Biologics Compendium;
(2) American Hospital Formulary Service-Drug Information (AHFSDI);
(3) Thomson Micromedex DrugDex;
(4) Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer-reviewed Professional journal.

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

f. Medications for cosmetic purposes only, except that medications shall be covered for medically diagnosed congenital defects and birth abnormalities and for any other conditions for which a medication is medically necessary.

g. Vitamins which by law do not require a prescription.

h. Drugs dispensed to you while a patient in a hospital, nursing home or other institution.

i. Over the counter drugs.

j. Contraceptives, except when coverage is required by state or federal law and made available by a Rider to your Plan.

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

Jay H. Wagner
Corporate Secretary

Mark Wagar
President

SCHEDULE A.1

Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Antirheumatic Agents	Actemra
Human Growth Hormone	Accretopin
Hormonal Therapy	Actar H.P.
Narcotic Analgesics	Actiq (fentanyl)
Antihypertensive	Adcirca
Antineoplastic	Afinitor
Antipsoriatics	Amevive
Multiple Sclerosis	Ampyra
Androgens	Androderm
Androgens	Androgel
Colony Stimulating Factor	Aranesp
Hormonal Therapy	Arixion
Cancer Treatment	Aromasin
Antineoplastic	Avastin
Antiallergy-opthalmic	Bepreve
Neuromuscular Blocker	Botox
Urea Cycle Disorder Treatment	Buphenyl
Thyroid Cancer	Caprelsa
Immune Globulin	Carimune NF
Enzyme	Ceredase
Enzyme	Cerezyme
Benign Prostatic Hyperplasia	Cialis
Tumor Necrosis Factor Inhibitor – Crohn's Disease	Cimzia
Skeletal Muscle Relaxants	Dysport
Arthritis	Euflexxa
Human Growth Hormone	Egrifta
Enzyme Replacement	Elelyso
Gonadotropin-Releasing Hormone Analogs	Eligard
Cancer Treatment	Emcyt
Tumor Necrosis Factor Inhibitor	Enbrel
Colony Stimulating Factor	Epogen
Antineoplastic	Erbitux
Cancer Treatment	Erivedge
Macular Degeneration	Eylea
Narcotic Analgesics	Fentora
Immune Globulin	Flebogamma
Antihypertensive	Flolan
Osteoporosis Agents	Forteo
Hormonal Therapy	Fortesta
Immune Globulin	GamaSTAN
Immune Globulin	Gammagard S/D
Immune Globulin	Gammagard liquid

Drug Class	Prescription Drug
Immune Globulin	Gamunex
Human Growth Hormone	Genotropin
Multiple Sclerosis	Gilenya
Antineoplastics	Gleevac
Cancer Treatment	Halaven
Antineoplastic	Herceptin
Human Growth Hormone	Humatrope
Antirheumatic Agents	Humira
Arthritis	Hyalgan
Hepatitis	Incivek
Growth Hormone	Increlex
Interferon	Infergen
Cancer Treatment	Inlyta
Interferon	Intron-A
Cancer Treatment	Jakafi
Cancer Treatment	Kalydeco
Antirhuematic Agents	Kineret
Cushing's Syndrome	Korlym
Phenylketonuria (PKU)	Kuvan
Pain Relief	Lazanda
Colony Stimulating Factor	Leukine
Gonadotropin-Releasing Hormone Analogs	Leuprolide
Antihyperlipidemic	Lipitor
Vascular Endothelial Growth Factor Inhibitor	Lucentis
Gonadotropin-Releasing Hormone Analogs	Lupron, Depot
Analgesics	Lyrica
Vascular Endothelial Growth Factor Inhibitor	Macugen
Pre-term Delivery Prevention	Makena
Neuromuscular Blocker	Myobloc
Colony Stimulating Factor	Neulasta
Myeloid Stimulant	Neumega
Colony Stimulating Factor	Neupogen
Antineoplastics	Nexavar
Human Growth Hormone	Norditropin
CNS Stimulant	Nuvigil
Antimetabolites	Oforta
Human Growth Hormone	Omnitrope
Anemia	Omontys
Narcotic Analgesics	Onsolis
Arthritis	Orencia
Pain Relief	Orexo
Arthritis	Orthovisc
Hepatitis	Pegasys
Hepatitis	Peg-Intron

Drug Class	Prescription Drug
Immune Globulin	Privigen
Colony Stimulating Factor	Procrit
Osteporosis	Prolia
Prostate Cancer	Provenge
CNS Stimulant	Provigil
Antimalarials	Qualaquin
Antirheumatic Agents	Remicade
Antihypertensive	Remodulin
Antihypertensive	Revatio
Immunomodulator	Revlimid
Antineoplastic	Rituxan
Hepatitis	Roferon-A
Human Growth Hormone	Saizen
Human Growth Hormone	Serostim
Arthritis/Psoriasis	Simponi
High Cholesterol	simvastatin
Antifungals	Sporanox
Antineoplastics	Sprycel
Antipsoriasis and Eczema	Stelara
Pain Releif	Subsys
Arthritis	Supartz
Opiod Dependence	Suboxone
Gonadotropin-Releasing Hormone Analogs	Supprelin LA
Antineoplastics	Sutent
Immunologicals	Synagis
Gonadotropin-Releasing Homone Analogs	Synarel Nasal Spray
Arthritis	Synvisc, One
Antineoplastics	Tarceva
Antineoplastics	Targretin (oral only)
Antineoplastics	Tasigna
Antineoplastics	Temodar
Androgens	Testim
Infection Prevention and Treatment	Terbinex
Immunomodulator	Thalomid
Anticonvulsants	Topamax
Gonadotropin-Releasing Hormone Analogs	Trelstar, Depot, LA
Antineoplastics	Tykerb
Antihypertensive	Tyvaso
Human Growth Hormone	Valtropin
Gonadotropin-Releasing Hormone Analogs	Vantas Implant
Antineoplastic	Vectibix
Antihypertensive	Ventavis
Antifungals	Vfend
Hepatitis	Victrelis
Immune Globulin	Vivaglobin

Drug Class	Prescription Drug
Opiod Antagonist	Vivitrol
Antineoplastics	Votrient
Gaucher's Disease	Vpriv
Cancer Treatment	Xalkori
Antineoplastics	Xeloda
Central Monoamine-Depleting Agent	Xenazine
Bone Fracture/Pain Due to Cancer	Xgev
Arthritis	Xiaflex
Antibiotic	Xifaxan
Monoclonal Antibody	Xolair
Cancer Treatment	Yervoy
Enzyme Inhibitor	Zavesca
Cancer Treatment	Zelboraf
Gonadotropin-Releasing Hormone Analogs	Zoladex
Antineoplastics	Zolinza
Human Growth Hormone	Zorbtive
Prostate Cancer	Zytiga
Antibiotic	Zyvox

SCHEDULE A.2

Step Therapy Drugs Subject to Prior Authorization

Drug Class	Prescription Drug
Proton Pump Inhibitor	Aciphex
Antiacne	Adoxa
Antiallergy-opthalmic	Alamast
Non-Sedating Antihistamine	Allegra ODT, Suspension, D
Antiallergy-opthalmic	Alocril
Antiallergy-opthalmic	Alomide
Migraine Medication	Alsuma
Antihyperlipidemic	Altoprev
Sedative/Hypnotics	Ambien CR
CNS Stimulant	amphetamine salt combo
Diabetes	Apidra
Non-Steroidal Antiinflammatories	Arthrotec
Diabetes	Avandament
Diabetes	Avandaryl
Diabetes	Avandia
Migraine Medication	Axert
Contraception	Beyaz
Diabetes	Blood Glucose Meters/Strips
Nasal Steroids	Beconase AQ
Antiacne - Topical	Benzaclin
Multiple Sclerosis	Betaseron

Drug Class	Prescription Drug
Osteoporosis	Boniva
Ovulatory Stimulants	Bravelle
Diabetes	Bydureon
Diabetes	Byetta
Non-Steroidal Antiinflammatories	Celebrex
Non-Sedating Antihistamine	Clarinex-D
Non-Sedating Antihistamine	Clarinex, Suspension
Proton Pump Inhibitor	Dexilant
Antiacne	Doryx
Pain Relief	Duexis
Sedative/Hypnotics	Edluar
Antiallergy-opthalmic	Elestat
Dermatological Agent	Elidel
Antiallergy-opthalmic	Emadine
Overactive Bladder Agents	Enablex
Pain Relief	Exalgo
Multiple Sclerosis	Extavia
Analgesics	Flector
Nasal Steroids	Flunisolide Nasal Spray
Migraine Medication	Frova
Overactive Bladder Agents	Gelnique
Contraception	Generess FE
Multiple Sclerosis	Gilenya
Ovulatory Stimulants	Gonal-F
Pain Relief	Indocin
Sleep Aid	Intermezzo
Diabetes	Januvia
Proton Pump Inhibitors	Kapidex
Antihyperlipidemic	Lescol, XL
Antihypertensive	Letairis
Antihyperlipidemic	Lipitor
Antihyperlipidemic	Livalo
Contraception	Loestrin 24 FE
Contraception	Loestrin FE
Antiacne	Minocin
Skin Condition	Morigdox
Overactive Bladder	Mybetriq ER
Pain Relief	Nalfon
Nasal Steroids	Nasacort AQ
Nasal Steroids	Nasarel
Contraception	Natazia
Contraception	Norinyl 1+50
Nasal Steroids	Omnaris
Diabetes	Onglyza
Antiallergy-opthalmic	Optivar

Drug Class	Prescription Drug
Contraception	Ortho Tri Cyclen Lo
Contraception	Ovcon 50
Overactive Bladder Agents	Oxytrol
Proton Pump Inhibitors	pantaprazole
Pain Relief	Pennsaid
Proton Pump Inhibitors	Prilosec
Proton Pump Inhibitors	Prevacid
Proton Pump Inhibitors	Protonix
Dermatological Agent	Protopic
Nasal Steroids	Qnasal
Migraine Medication	Relpax
Nasal Steroids	Rhinocort Aqua
Sedative/Hypnotics	Rozerem
Contraception	Safyral
Addiction	Suboxone
Sleep Aid	Silenor
Antiacne	Solodyn
Overactive Bladder Agents	Sanctura
Sedative/Hypnotics	Sonata
Migraine Medication	Sumavel DosePro
Diabetes	Tradjenta
Migraine Medication	Treximet
Gout Medications	Uloric
Mental Health	Viibryd
Diabetes	Victoza
Antihyperlipidemics	Vytorin
Non-Sedating Antihistamine	Xyzal, Syrup
Antiacne	Veltin
Proton Pump Inhibitors	Zegerid
Antihyperlipidemics	Zetia
Nasal Steroids	Zetonna
Skin Condition	Ziana
Sleep Aid	Zolpimist

EMPIRE HEALTHCHOICE ASSURANCE, INC.

ORAL CONTRACEPTIVE PRESCRIPTION DRUG COVERAGE RIDER

This Rider amends the Prescription Drug Rider of Your Contract or Certificate as follows:

Coverage is available for oral contraceptives and patches when provided by a participating retail or mail order pharmacy. Covered prescription drugs and devices must be approved by the federal Food and Drug Administration and must be issued by a healthcare provider legally authorized to issue the prescription order. Prescription orders for may be dispensed up to a 90 consecutive day supply.

- Generic and single-source brand name covered prescription drugs will be paid in full, subject to no member cost-share; and

- Multi-source brand name covered prescription drugs are subject to the same applicable member cost-share (i.e., Deductible, Coinsurance or Copayments) as other drugs and devices under the Prescription Drug Rider to which this Rider is attached.

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

Jay H. Wagner
Corporate Secretary

Mark Wagar
President

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.

Empire BLUECROSS BLUESHIELD

RIDER TO EMPIRE HEALTHCHOICE ASSURANCE, INC. GROUP CONTRACT OR CERTIFICATE

The Contract or Certificate to which this Rider is attached is changed as follows:

1. The following is added to Article III of the Contract or Certificate to which this Rider is attached:

   In-network benefits for hospital, facility and medical services are subject to the cost sharing amount as set forth on the Schedule of Benefits. Any applicable Deductible and Coinsurance will not apply to a service which is subject to a copayment, except that it will apply to inpatient admissions which are subject to a copayment.

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

Nancy L. Purcell
Corporate Secretary

Mark Wagar
President

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.

P.O. Box 1407, Church Street Station
New York, NY 10008-1407

RIDER TO EMPIRE HEALTHCHOICE, INC.
CONTRACT OR CERTIFICATE

The Contract or Certificate to which this Rider is attached is amended as set forth below.

1. The penalty referred to in the Medical Management Program section of this Contract is changed and all references to $5,000 are deleted and replaced with $2,500.

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

PETER LIRIA, JR.
SECRETARY

MICHAEL A. STOCKER, M.D.
PRESIDENT
AND
CHIEF EXECUTIVE OFFICER

A licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

P.O. Box 1407, Church Street Station
New York, NY 10008-1407

EMPIRE HEALTHCHOICE, INC.
Rider Providing
DEDUCTIBLE and COINSURANCE CARRYOVER RIDER

This Rider increases coverage under your Empire HealthChoice, Inc. Contract or Certificate.

1. **Replacement of Another Carrier's Group Contract.** If on the day before the Effective Date of this Contract, a Covered Person was covered under a group major medical or comprehensive type contract issued to your Group by another carrier, any deductible expenses incurred by the Covered Person under the other contract during the same calendar year will be applied to the satisfaction of any deductible required under this Contract during the same calendar year for such Covered Person.
2. **Replacement of Another Empire Group Contract.** If on the day before the Effective Date of this Contract, a Covered Person was covered under a group major medical or comprehensive contract issued to your Group by us, any covered expenses applied to the deductible and coinsurance for each Covered Person under the prior group contract will be applied toward the satisfaction of any deductible and coinsurance required under this Contract during the same calendar year for such Covered Person.
3. **Annual Deductible Carryover.** If a Covered Person had any expenses applied to the deductible in the last three months of a calendar year, such covered expenses also will be applied to the Out-of-Network deductible for the next calendar year.
4. All the terms and limitations of your Empire HealthChoice, Inc. Contract or Certificate also apply to this Rider.

PETER LIRIA, JR.
SECRETARY

MICHAEL A. STOCKER, M.D.
PRESIDENT
AND
CHIEF EXECUTIVE OFFICER

A licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

EMPIRE HEALTHCHOICE ASSURANCE, INC.
DOMESTIC PARTNER RIDER

This Rider changes coverage under your Empire HealthChoice Assurance, Inc. Certificate of coverage.

1. Domestic Partners Covered. The section of your Certificate, entitled "Group Enrollment," is hereby amended to add a Domestic Partner as a covered family member to the extent that the group's plan covers domestic partners as family members. A domestic partner is an individual who has entered into a domestic partnership with the person to whom the Certificate is issued.

2. Domestic Partnership Defined. A domestic partnership means:

   A. Two people both eighteen (18) years of age or older, who are not related by blood in a manner that would legally prohibit their marriage. Neither person is married. Neither person has had another domestic partner within the last six (6) months.

   B. The persons have been living together on a continuous basis for at least six (6) months. The persons intend to continue to live together indefinitely. Proof of cohabitation must be submitted and includes: a driver's license; tax return; or other sufficient proof as determined by Empire HealthChoice Assurance, Inc.

   C. The two persons are registered as domestic partners, when registration is available; or the two persons submit an affidavit of domestic partnership. The registration statement or affidavit must be submitted to verify the domestic partnership.

   D. The financial interdependence of the domestic partners is established by evidence of two or more of the following, proof of which must be submitted:

      - Joint bank account.
      - Joint credit or charge card.
      - Joint obligation on a loan.
      - Joint ownership of residence or other real estate.
      - Joint tenants on a lease or shared rental payments of residence or other property.

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- A common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills).
- Joint ownership of vehicle or major items of personal property.
- Wills having each other as executor and/or beneficiary.
- Designation as beneficiary under the other's retirement benefits plan.
- Mutual grant of authority as health care proxy.
- Mutual grant of durable power of attorney.
- Status as authorized signatory on other's credit card, charge card or bank account.
- Joint ownership or holding of investments.
- Shared household budget for purposes of government benefits.
- Status of one as payee of the other's government benefits.
- Joint responsibility or shared expenses for child care.
- Such other items as may be sufficient under the facts of a particular case.
- Affidavit of creditor or other individual able to testify to partners' financial interdependence.

E. The domestic partnership is verified by the submission of the three (3) categories of proof described in B, C and D above.

F. When Domestic Partner Coverage Begins. If we receive written notice that a member has entered into a domestic partnership within sixty (60) days after it is entered into, coverage for the domestic partner starts on the effective date of the domestic partnership. Otherwise, coverage of the domestic partner begins on the date on which we receive and accept from the group a completed copy of the Notice of Election, during the next open enrollment period.

G. Termination of Domestic Partnership. The persons agree to file a termination statement in the event of termination of the domestic partnership. Coverage of the non-employee domestic partner will terminate upon termination of the domestic partnership. If a person's group coverage ends because his or her domestic partnership has ended, he or she may purchase an individual direct payment coverage.

3. Dependents of Domestic Partners. The definition of "Children" under the Certificate will include children of your domestic partner who are otherwise eligible for coverage under your Certificate.

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

Nancy L. Purcell
Corporate Secretary

Mark Wagar
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

PATIENT PROTECTION AND AFFORDABLE CARE ACT RIDER

This Rider changes provisions in, or adds provisions to, your Contract, Certificate or Group Plan, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively "Your Plan") issued by Empire HealthChoice Assurance, Inc. as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided in this Rider, the provisions herein apply to all persons covered under "Your Plan" ("Members"). This Rider shall be effective on the later of August 1, 2012 or the initial effective date of Your Contract.

1. **Emergency Services.**

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

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

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

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

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

   4. Serious disfigurement of such person.

   B. **Emergency Services Defined.** The following definitions are hereby added to your Contract:

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

Stabilize. With respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility or to deliver a newborn child (including the placenta.

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

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

E. **Our Payments.** The amount we pay an Out-of-Network Provider for Emergency Services will be the greater of: (1) the amount we have negotiated with In-Network Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Allowable Amount provided by an Out-of-Network Provider under Your Plan, i.e., the amount we would pay in the absence of any cost-sharing that would otherwise apply for services of Out-of-Network Providers; (3) or the amount that would be paid under Medicare. The amounts described in (1), (2), and (3) exclude any Copayment or Coinsurance that applies to Emergency Services provided by an In-Network Provider.

F. **Your Payments.** You are responsible for any applicable Deductible, Copayment, or Coinsurance and for the Out-of-Network Provider charges that exceed Our Payments.

2. **Preventive Services.** To the extent items and services in the sources referenced below are not already covered services for adults and children under Your Plan, benefits for the items and services are hereby added to Your Plan:

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

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

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

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

   Examples of these services are screenings for:

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

B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations;

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

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

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

In addition, coverage is available for generic and single-source brand name prescription drugs for oral contraceptives and patches dispensed from a pharmacy. To obtain benefits, prescription drugs must be approved by the federal Food and Drug Administration and must be obtained from a retail or mail order pharmacy that is a member of our Pharmacy Network. Please see the Oral Contraceptive Prescription Drug Rider for more information.

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

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

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

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

3. **Access to OB/GYNs.** Any provision in Your Plan that limits the number of visits you can make to an In-Network Provider who specializes in obstetrics or gynecology without a referral from your Primary Care Physician is hereby deleted in its entirety. You do not need prior authorization from us or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from an In-Network Provider who specializes in obstetrics or gynecology. The In-Network Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of In-Network Providers who specialize in obstetrics or gynecology, contact us at the Customer Service number on your identification card.

4. **Annual Limits.** Any annual dollar limit under Your Plan that applies to Essential Benefits, whether such annual limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act.

5. **Pre-Existing Conditions.** Under this Rider, the provision, if any, in Your Plan that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Contract for a stated period is hereby deleted in its entirety with respect to all Members under the age of 19.

6. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under is hereby deleted in its entirety.

7. **Dependent Children Covered to Age 26.** If Your Plan makes coverage of dependents available, this Rider applies to coverage of children as follows:

   A. If you selected other than individual coverage, your children who are under the age of 26 may be covered under Your Plan. Coverage lasts until the end of the month in which the child turns 26 years of age. Your children need not be financially dependent upon you for support or claimed as dependents on your tax return; residents of your household; enrolled as students; or unmarried. Children-in-law (spouses of children) and grandchildren are not covered under this Rider.

Coverage for Your child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, or physical handicap and who became so incapable prior to attaining age 26 shall not terminate while Your Plan remains in effect and the child remains in such condition, if You submit proof of Your child's incapacity within 31 days of Your child's attaining age 26.

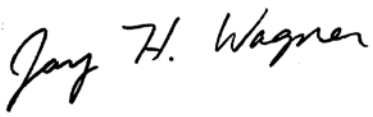
B. "Children" include your natural children, a legally adopted child; a step child; and a child for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption period. Coverage lasts until the end of the month in which the child turns 26 years of age.

C. Coverage shall be provided for any unmarried dependent child, regardless of age, who is incapable of self- sustaining employment because of mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law, or because of physical handicap and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.

D. The provisions of any Rider to Your Plan that extends coverage for young adults through age 29 (for example, the provision requiring that the child be unmarried) shall remain in effect for children ages 26 through 29 and are not changed by provisions set forth above in this Paragraph 7 that apply to children under the age of 26.

8. **Material Distribution.** We will provide the group contract holder, and the group contract holder will provide Covered Persons with, identification cards, Certificates, Riders and other materials provided by us to the group contract holder as necessary to inform Members of the terms of their coverage.

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



Jay H. Wagner
Corporate Secretary

Mark Wagar
President

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

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

> This Rider relates to the twelve (12) month period used to calculate your annual Deductible and coinsurance maximum and annual benefit maximums and limitations that are listed in your Contract or Certificate or on your Schedule of Benefits. The twelve (12) month period that applies for this purpose is "Calendar Year."

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

Jay H. Wagner
Corporate Secretary

Mark Wagar
President

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.

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ARTICLE I - GENERAL INFORMATION

A. Introduction. This Contract explains the group's coverage with Empire HealthChoice, Inc. In this Contract, "we," "us," "our" and "the Plan" refer to Empire HealthChoice, Inc. "You," "your" and "yours" refer to the Covered Member. "Group" refers to the Group that buys this Contract. Employees or members who are covered under this Contract, as stated in the application, are referred to as "Members." Members and their covered family members are referred to as "Covered Persons." Use of the word "he" in this Contract refers to he or she.

No statement the Covered Person or the Group makes will avoid the insurance provided by this Contract, or reduce its benefits, unless it is contained in a written document signed by the Covered Person or the Group. All statements contained in such a document will be deemed representations, not warranties.

B. Definitions

1. **Allowed Amount.** The Allowed Amount is the maximum available benefit for each covered service under this Contract when such services are determined by Empire to be medically necessary and appropriate. For services covered under the medical portion of the contract the Allowed Amount may be based on an agreement between Empire and the Provider. If there is no agreement the Allowed Amount will be based on the Customary Charge. For hospital and/or facility services the Allowed Amount is based on an agreement between Empire and the hospital and/or facility. If there is no agreement, then the Allowed Amount will be no greater than the average of amounts paid by Empire for comparable services in like kind participating hospitals and/or 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 Empire for comparable services in like kind participating hospitals and/or facilities in the contiguous county or counties.

   Customary Charges are determined based on charge data collected by Empire from Providers or from other recognized sources. Charge data is collected and reviewed for services rendered in a geographical area during a particular data collection period. Customary Charges are established at the amount Empire would have paid for most of the services reviewed. Empire reviews the Customary Charges in order to determine their reasonableness. The period during which Customary Charges are in effect will be later than the respective data collection period.

2. **Coinsurance.** The payment, expressed as a percentage of the Allowed Amount, which must be satisfied by the Covered Person.

3. **Copayment.** The payment, expressed in dollars, that must be made by the Covered Person for certain services.

4. **Covered Person.** A Member and his covered family dependents, as defined under Section D of this Article. The term "Member" means either an employee or member of a group.

5. **Covered Services.** The services for which the Covered Person is entitled to receive benefits under the terms of this Contract.

6. **Deductible.** The payment, expressed in dollars, which must be satisfied by the Covered Person before we will pay any benefits.

7. **Doctor.** A doctor means a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

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

9. **Facilities.** Facilities are providers which administer benefits for ambulatory surgery, outpatient treatment for alcoholism and substance abuse, home health care, dialysis, hospice care and skilled nursing facilities.

10. **Hospital.** A Hospital means a fully licensed acute care general hospital that has on its own premises all of the following:

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

    The following providers are not considered Hospitals as defined in this Contract: nursing or convalescent homes and institutions; rehabilitation facilities (unless such a facility has a network agreement with us); institutions primarily for rest or for the aged; spas; sanitariums; infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism, or mental or nervous disorders.

    For purposes of care for pregnancy, childbirth and its complications, the definition of "Hospital" includes any Birthing Center which is an In-Network Provider.

11. **In-Network Provider.** In-Network Provider means a professional Provider, or a Hospital or Facility which has a participating agreement with Empire to provide services for our PPO contracts or another Blue Cross Blue Shield Plan's BlueCard PPO program, to provide covered services to persons insured under this Contract. This definition applies to all references to participating provider or in-network provider, unless the contract specifically states otherwise.

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

13. **Medical Necessity or Medically Necessary.** Under this Contract, unless otherwise stated, we will not pay for any treatment, service or supply that we determine is not medically necessary. Medically Necessary means care which, according to our criteria, and in our judgment, is:

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

14. **Out-of-Network Benefits.** Out-of-Network Benefits are covered services which have been have provided by, (1) Hospitals and Facilities which are not In-Network Providers; or (2) professional providers who are not In-Network Providers.

15. **Provider.** Provider means an individual (professional Provider) or entity (Hospital or Facility) that provides covered benefits to persons eligible for coverage under this Contract.

16. **Medical Management Program.** The Medical Management Program is the managed care program described in Article II. The Covered Person must comply with the Medical Management Program in order to receive the maximum benefits available under this Contract.

17. **Blue Cross and Blue Shield Association Blue Card Program.** Empire HealthChoice, Inc. participates in a national program administered by the Blue Cross and Blue Shield Association called the BlueCard Program. The BlueCard Program gives Empire members access to care when they are outside of Empire's service area. By presenting their Empire identification card to any Blue Cross and/or Blue Shield participating hospital, physician or other provider outside of Empire's service area anywhere in the United States, Empire members are assured that they will receive the covered services they would be entitled to receive within Empire's service area and that they will benefit from the discounts that the participating providers have agreed to extend to their local Blue Cross and/or Blue Shield Plan. Member liability for covered services for claims incurred outside Empire's service area and processed through the BlueCard Program, in most instances, will be based on the lower of:

    - The out-of-area participating provider's actual billed charges for the covered services provided, or
    - The negotiated price for the covered services that the out-of-area Blue Cross and/or Blue Shield Plan passes on to Empire.

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

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

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

    Covered Persons must receive services from In-Network Providers who participate in another plan's Blue Card PPO program in order to receive in-network benefits under this contract.

    If a Covered Person receives services from hospitals or facilities which are outside our service area and its contiguous counties, and which do not participate with any Blue Cross or Blue Shield Plan, we will pay the lesser of charges or an agreed upon rate.

C. Empire Contract

1. **General Information.** Each Covered Person is entitled to receive the Hospital, Facility and medical benefits described in this Contract. The level of reimbursement and, at times, availability of benefits described in this Contract will vary depending on whether the services are received In-Network or Out-of-Network. The number of days or visits available for the services described in this Contract as well as the applicable levels of deductibles, coinsurance and copayments are set forth in the Schedule of Benefits.

2. **Covered Services.** Unless the Covered Person is totally disabled as provided in Article XVIII, Section F, benefits are available only for services rendered while a person is covered under this Contract and only for Covered Services. If the Covered Person is totally disabled when this Contract terminates and coverage is available for the total disability under another group Contract, whether insured or self-insured, we will not provide any additional benefits under this Contract after the termination date.

D. Group Enrollment. The group application describes which of the group's employees or members are eligible to be covered by the Contract. Any person or family member who is eligible for Medicare is not eligible for coverage under this Contract unless they are eligible for coverage under Article XIII, Section C. Any eligible person, in order to obtain coverage for himself and other eligible persons in his family as described below, must complete and return to the group a Notice of Election. Section E of this Article explains how to obtain coverage for new dependents of the Covered Person's family. This Notice must be in a form approved by us. The term "Member" means either the employee or a member of the group.

All new employees or new members in the classes eligible for insurance must be added to such class for which they are eligible.

If a Member has family coverage, for purposes of eligibility under this Contract, a Member's "family" means the Member and the following persons, but only if they are listed on the Notice of Election:

1. Spouse - the Member's husband or wife, but not a former husband or wife (as a result of divorce or annulment of a marriage).

2. Children - the unmarried, dependent, natural or adopted children of the Member or his or her spouse who are listed on the Notice of Election and are under the age set forth on the Schedule of Benefits, and any children born to the Member or the Member's spouse while covered under this Contract. Foster children are not covered.

3. Adopted Children

   a. Proposed adoptive children dependent on the Member pending finalization of the adoption are covered.

   b. Coverage of adopted newborns is available from the moment of birth if the Member has, or switches to, family coverage, and:

      i. The proposed adoptive parent(s) take physical custody of the infant as soon as the infant is released from the hospital after birth; and
      ii. The proposed adoptive parent(s) file a petition pursuant to New York Domestic Relations Law section 115-c within 30 days of the infant's birth.

   c. We will not cover adopted newborns from the moment of birth if:

      i. One of the natural parents revokes consent to adoption, or
      ii. If a notice of revocation of the adoption is filed.
      iii. If one of the child's natural parents has coverage for the newborn's initial hospital stay, we are not required to provide hospital benefits for that stay but must provide other benefits in connection with that stay and for all care subsequent to that stay, that are covered under the Contract.

      In the event of either ii or iii, we are entitled to recover any benefits paid for care of the adopted newborn.

4. Coverage for a child continues until:

   - the end of the year in which the child reaches the age set forth in the Schedule of Benefits; or
   - the end of the year in which the child reaches the age set forth in the Schedule of Benefits if the child is a registered full-time student in an accredited college or University; or
   - the child is no longer dependent on the Member or the Member's spouse; or
   - the date of marriage, whichever is earliest.

5. Incapacitated Children - any children who are unmarried and, in our judgment, incapable of self-sustaining employment because of any of the following: mental illness, developmental disability or mental retardation (all as defined in the New York Mental Hygiene Law) or physical handicap. Such incapacitating condition

must have started while the child is an eligible dependent, under paragraph 2 above, and it must be certified by a doctor, when requested by us.

E. When Coverage Under The Group Begins. Coverage for benefits provided under this Contract begins as outlined below. The Group will be billed for coverage as of the Effective Date of coverage.

1. If a Member elects coverage before becoming eligible for coverage, his coverage begins on the date he becomes eligible, or on the date on which we receive, and accept from the group, a completed copy of the Notice of Election, whichever is later.

2. If a Member elects coverage after becoming eligible, his coverage begins on the date on which we receive, and accept from the group, a completed copy of the Notice of Election, during the open enrollment period.

3. If a Member marries while covered, and we receive notice of such marriage within sixty (60) days thereafter, coverage for the Member's family starts on the date of such marriage, otherwise family coverage begins on the date on which we receive, and accept from the group, a completed copy of the Notice of Election, during the open enrollment period.

4. If a Member has family coverage, his newborn child or a proposed adopted child described in Section D(2) of this Article will automatically be covered from the date of birth. If a Member has individual coverage, he must notify us of his desire to switch to family coverage within 30 days from the date of birth; otherwise family coverage begins on the date on which we receive, and accept from the group, a completed copy of the Notice of Election, during the open enrollment period.

5. An eligible Member or dependent of a Member who rejects initial enrollment under this contract, can become covered under this contract if the following conditions are met:

   a. the Member or dependent was covered under another plan at the time coverage under this contract was initially offered, or

   b. i. coverage was provided in accordance with continuation required by federal or state law and was exhausted, or
      ii. coverage under the other plan was subsequently terminated as a result of loss of eligibility for one or more of the following: termination of employment; termination of the other plan; death of the spouse; legal separation; divorce or annulment; reduction in the number of hours of employment, or
      iii. contract holder contributions toward the payment of premium for the other plan were terminated.

   Coverage must be applied for within thirty (30) days of termination for one of the reasons described in this section.

F. Plan Area. Our Plan Area consists of twenty-eight (28) counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

G. Benefit Maximums. No maximum applies to In-Network benefits available under this Contract, however, there is a total aggregate lifetime benefit maximum, as listed in the schedule of benefits per Covered Person for Out-of-Network benefits under this Contract and all other contracts or certificates issued by us.

H. Payment of Premiums. The Group agrees to pay us premiums in the amounts and at the intervals set forth in the application. We may adjust the amount of premiums payable by the group on thirty (30) days' written notice prior to the start of each new contract period. If premiums have been prepaid, we will adjust the amount of premiums, as of the Effective Date, including retroactive adjustments, if necessary, to reflect any change in the amount of premiums as set forth above and bill for any additional premiums due.

Except for payment of the initial premiums in each contract period, there is a 30 day grace period after the due date shown on the bill during which payment may be made. If we do not receive payment in full within the grace period, the contract will automatically end without notice as of the due date shown on the bill. Claims incurred during the grace period are not eligible for payment unless the contract is reinstated. If we receive payment after this was terminated for failure to pay premiums, this may be reinstated at our option and, if reinstated, we will accept late payment and we will charge interest and a reinstatement fee. In such event, the Group agrees to pay us interest in the amount of twenty-four (24%) percent per year or the Citibank prime rate as of the first day of the month, plus two (2%) percent, whichever is greater, on all unpaid amounts. This interest will be computed from the expiration of the grace period shown on the bill until the day we receive payment in full. However, in no event shall the interest rate exceed the maximum amount allowed by law.

ARTICLE II - THE MEDICAL MANAGEMENT PROGRAM

A. A Prerequisite for Benefits Provided Under This Contract

1. The Medical Management Program (MMP) is a program which the Covered Person must comply with in order to be eligible to receive the maximum In-Network and Out-of-Network benefits available under this Contract. M.M.P. works with Covered Persons and/or their doctors to ensure that Covered Persons receive medically appropriate health services at an appropriate level of medical care.

   The Covered Person is responsible for ensuring that the pre-certification requirements are met unless this contract specifically states otherwise. The Covered Person, the provider or someone else on behalf of the Covered Person, may telephone MMP for pre-certification.

   If the requirements described in this Article are not met, we will apply the penalty described on the in-network or out-of-network benefits otherwise available under this Contract.

   The penalties listed in this Article are in addition to deductible and coinsurance maximums and annual out-of-pocket maximums listed in the schedule of benefits. They do not apply to the satisfaction of these maximums.

2. The Covered Person must call the Mental and Behavioral Health Care Manager for authorization prior to receiving the following services or a penalty will be imposed on benefits otherwise available:

   - Inpatient or outpatient mental health care (covered in-network only)
   - Inpatient Alcohol and Substance Abuse Detoxification (covered in-network only)
   - Outpatient alcohol and substance abuse care (covered both in-network and out- of-network)

   If the Covered Person does not call and comply with this requirement penalties will be applied as listed below:

   - Inpatient Mental Health and Alcohol and Substance Abuse Detoxification Admission-50% on each admission up to $5,000 per admission. The penalty also applies to the professional visits for services rendered during an inpatient admission.
   - Outpatient Mental Health Visits-50% on each visit.
   - Outpatient alcohol and substance abuse facility or provider visits-50% on each visit.

   The mental and behavioral health care manager can be contacted at the telephone number listed on the covered person's identification card.

3. The following services are covered both in-network and out-of-network and must be preauthorized by MMP. **Failure to precertify will result in a penalty of 50% up to $5,000 on each visit, or each admission, for the following services.** The penalty also applies to the professional visits for services rendered during inpatient admissions and ambulatory surgery.

- All inpatient admissions, including admissions for illness or injury to newborn's
- Ambulatory Surgery
- Cardiac rehabilitation
- Home Care

4. The following services are covered as in-network only and do not require prior authorization from MMP.

   - Laboratory services
   - Radiology services

5. The following services are covered as in-network only and must be preauthorized by MMP. Failure to precertify will result in a penalty of 50% up to $5,000 on each visit or each admission. The penalty also applies to the professional visits for services rendered during an inpatient admission.

   - Hospice
   - Occupational and Speech Therapy
   - Physical Therapy
   - MRIs
   - Skilled Nursing Facility

6. The following services are covered as in-network only and must be pre-authorized by MMP:

   - Home infusion therapy.
   - Durable Medical Equipment and Prosthetics and Orthotics.

7. The Covered Person or his attending doctor or Home Health Agency or Durable Medical Equipment and Prosthetics vendor must call MMP:

   a. At least two weeks prior to the planned admission or surgery when a doctor recommends inpatient hospitalization. If that is not possible, then during regular business hours anytime prior to surgery.

   b. Within twenty four (24) hours after a covered person is admitted to a hospital because of an emergency, or as soon as reasonably possible.

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

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

   c. Within the first three months of a pregnancy and again within 24 hours after the actual delivery date.

   d. Before receiving care in a skilled nursing facility or hospice.

   e. Before receiving home infusion therapy or home care services.

   f. Before receiving MRI services

g. At least two weeks prior to all ambulatory surgery or any ambulatory care procedure when a doctor recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in a free standing ambulatory surgery facility. If that is not possible then during regular business hours any time prior to surgery. If a Covered Person receives care as a Hospital inpatient for the types of services which could be performed on an outpatient basis, we will provide only the reimbursement we would have paid for ambulatory surgery.

h. Before receiving physical, occupational or speech therapy.

i. Before purchasing or renting Durable Medical Equipment, Prosthetics or orthotics, or purchasing supplies.

8. The MMP staff can be contacted at the number indicated on your personalized Identification Card.

9. The staff will discuss the planned level of care with the Covered Person and his attending doctor to determine a level of care which is appropriate to the planned health services and advise the Covered Person, his attending doctor, and the Hospital in writing and by telephone of the approved level of care within three (3) business days after the staff receives all the necessary medical information from the attending physician. If during a hospitalization or course of treatment you need authorization for continued or extended health care, the Medical Management Program will respond within one business day of receiving the necessary medical information.

10. The preauthorization of benefits by the MMP or the mental and behavioral health care manager does not guarantee payment of benefits. All benefits must be medically necessary as determined by us. The payment of benefits is limited by the terms, conditions and limitations of this Contract.

B. Case Management

1. We may have access to and review on a concurrent basis any of the Covered Person’s hospital and other medical records to evaluate alternative benefit possibilities.

2. The Medical Management Program will perform case management for Covered Persons with chronic debilitating or catastrophic illness or injury by providing assistance and/or explanation of treatment decisions.

C. The Medical Management Program Appeals

1. A Covered Person whose benefits have been reduced or denied under the MMP may appeal this decision within sixty (60) days of a benefit reduction or within sixty (60) days after a claim is denied

   a. if he believes that extenuating circumstances prevented him from complying with the requirements of the MMP; or

   b. if he followed his treating doctor's recommendation although it was contrary to the MMP's opinion as to the level of care appropriate to the health services received; or

   c. if he believes that his benefits were otherwise incorrectly reduced or denied under the MMP.

   Claims which are not appealed within the sixty (60) day period are not eligible for review.

2. Appeal of MMP decisions may be submitted in writing or by telephone.

3. Appeals of medical necessity denials are reviewed by the MMP physician.

4. The MMP staff will advise the Covered Person, his attending doctor and Hospital of its decision on appeal within sixty (60) days after it receives all necessary Hospital or medical records related to the care the Covered Person received.

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

   - Continuations or extensions of health care services, procedures or treatments already begun;
   - Additional care during an ongoing course of treatment; or
   - A case in which the provider believes an appeal is justified.

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

   - Empire will provide you or your provider with reasonable access to our clinical reviewer within one business day of receiving a request for an expedited appeal.
   - We will make a decision on an expedited appeal within two business days following receipt of all necessary information about the case.
   - Empire will notify you immediately of the decision by telephone and in writing within two business days.
   - If the Covered Person is not satisfied with the resolution of the expedited appeal, a further appeal may be made through the standard appeal process, as described in this subsection.

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

6. External Appeals.

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

   - An external appeal is an independent review of a coverage determination by a third party known as an External Appeal Agent. External Appeal Agents are certified by the State, and may not have a prohibited affiliation with any health insurer, health maintenance organization (HMO), medical facility, or health care provider associated with the appeal.

   - You may have the right to an expedited external appeal if your attending physician attests that a delay in providing the requested service would pose an imminent or serious threat to your health. The timeframes for expedited external appeals are shorter than the timeframes for standard external appeals.

   - You may request an external appeal by filing a standard external appeal request form with the New York State Insurance Department. If the requested service has already been provided to you, your physician may file an appeal on your behalf. We will send a standard request form to you when we have made a final adverse determination. You or you physician may obtain additional standard request forms at any time from the State Insurance Department, the Department of Health, or by contacting us.

   - You must file your request for an external appeal with the State Insurance Department within 45 days of receiving a final adverse determination or within 45 days of receiving a letter from us waiving our internal review process. We do not have the authority to grant extensions of this deadline.

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

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

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

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

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

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

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

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

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

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

Further information regarding member rights is set forth in the Member Disclosure Statement.

ARTICLE III – IN-NETWORK BENEFITS - HOSPITAL/FACILITY AND MEDICAL BENEFITS

A. Hospital Services

1. Each Covered Person is eligible to receive Hospital benefits described in Articles V and VI from participating Hospitals and participating ambulatory surgery Facilities subject the MMP requirements described in Article II of this Contract. Each inpatient admission to a Hospital or a Facility is subject to a copayment as set forth in the Schedule of Benefits. The copayment shall be paid once for a continuous hospital confinement, which includes discharge and readmission within 90 days. A confinement for an accident shall not be combined with another confinement for an illness in determining continuous hospital confinement.

2. Each emergency room visit is subject to the copayment listed in the schedule of benefits unless the Covered Person is admitted to the hospital within twenty-four (24) hours of the visit.

3. The benefits for mental health care including alcohol and substance abuse benefits covered under this Contract must be preauthorized by the mental and behavioral health care manager. Each mental health inpatient admission is subject to a copayment as set forth in the Schedule of Benefits.

Only In-Network benefits are available for inpatient mental health care and inpatient alcohol and substance abuse.

B. In-Network Benefits: Facility and Medical Service

1. **In-Network Medical Service.** The Covered Person will receive in-network benefits for Covered Services described in Article XII from In-Network providers. The benefits are subject to the copayments listed in the Schedule of Benefits. Copayments will be applied for each visit of the following visits in a facility or provider's office:

   - Annual Physicals
   - Consultations
   - Diabetes Education and Management
   - Home/Office visits
   - Outpatient Mental Health Care
   - Physical, Occupational, Speech Therapy
   - Hearing Evaluations
   - Well Woman Examinations
   - Allergy Testing
   - Cardiac Rehabilitation

   No copayment applies when a consultation is rendered in connection with an inpatient admission.

   Only In-Network benefits are available for outpatient mental health care.

2. **In-Network Facility Services.** Facilities for outpatient ambulatory surgery, home care, and dialysis must have participating agreements with us or another Plan in order to be in network. Benefits for ambulatory surgery, home care and skilled nursing must be preauthorized by MMP as set forth in Article II.

The Professional and Facility services for mental health care including alcohol and substance abuse must be authorized in advance by the Mental and Behavioral Health Care Manager to be in network.

ARTICLE IV – OUT-OF-NETWORK BENEFITS

A. Out-of-Network Benefits Apply When:

1. The Covered Person receives services in a Hospital or Facility that is not an In-Network Provider, or

2. The Covered Person goes to a professional provider who is not an In-Network Provider.

3. If the Covered Person does not receive prior written authorization from the Mental and Behavioral Health Care Manager for out-of-network outpatient benefits for alcohol and substance abuse, those benefits will be subject to the penalties listed in Article II.

B. Out-of-Network Deductible and Coinsurance

1. Deductible. The Out-of-Network deductible amount will be applied to each Covered Person per calendar year up to the deductible maximum per covered family for each calendar year. The deductible amounts are set forth in the Schedule of Benefits.

2. Coinsurance. After the out-of-network deductible is satisfied, the out-of-network coinsurance applies on a calendar year basis. Covered Persons are responsible for the amounts not covered, or in excess of the Allowed Amount. Each year for each Covered Person we will pay the percentage indicated on the Schedule of Benefits until the maximum coinsurance indicated on the Schedule of Benefits is reached. For the remainder of the year, the Covered Person will not be required to pay coinsurance.

Outpatient alcohol and substance abuse benefits are subject to the out of network deductible and coinsurance set forth in the Schedule of Benefits. The coinsurance for outpatient alcohol and substance abuse will be applied toward the satisfaction of the coinsurance maximum listed on the Schedule of Benefits.

Covered Persons are responsible for the payment of amounts not covered or in excess of the Allowed Amount.

There are situations, as stated in this Contract, where no Out-of-Network benefits are available.

C. Out-of-Network Hospital and Facility Reimbursement

1. Hospital. If the Covered Person does not go to an In-Network Hospital the benefits will be out of network subject to the out of network deductible and coinsurance requirements of this Contract.

No Out of Network benefits are available for inpatient mental and behavioral health care benefits including inpatient alcoholism and substance abuse care.

2. Facility. If the Covered person does not go to participating facilities for benefits described in Articles VI, VII, VIII, and IX the benefits will be out of network. There are no out-of-network benefits for Skilled Nursing Facility or Hospice care.

3. Reimbursement. If the Hospital or Facility is not an In-Network Provider, we will pay our Allowed Amount for services received in Out-of-Network Hospitals and Facilities. These benefits are then subject to the Out-of-Network deductible and coinsurance requirements described in the Schedule of Benefits.

We will not pay more for any specific service than the Allowed Amount, or the actual charge. Any difference between the Provider's actual charge and the Allowed Amount as determined by us for the service provided is the Covered Person's responsibility and is not applied to the Out-of-Network deductible and coinsurance maximums under this Contract.

D. Out-of-Network Medical Benefits Reimbursement. If the Covered Person receives services described in Article XII from an Out-of-Network Provider, the Covered Person's benefits will be paid subject to the Out-of-Network deductible and coinsurance, except that no coverage is available for those benefits which are listed as in-network only.

We will not pay more for any specific service than the lower of the Allowed Amount, or the actual charge. Any difference between the Provider's actual charge and the Allowed Amount as determined by us for the service provided is the Covered Person's responsibility and is not applied to the Out-of-Network deductible and coinsurance maximums under this Contract.

ARTICLE V - INPATIENT HOSPITAL BENEFITS

A. Qualification for Inpatient Hospital Benefits. To qualify for inpatient Hospital benefits, as defined in Article I, Section B(9) of this Contract, a Covered Person must be a registered bed patient in a Hospital and under the care of a doctor for the treatment of illness, injury or pregnancy and for which treatment cannot be safely and effectively provided on an outpatient basis. Inpatient hospital benefits described in this Article are subject to the MMP requirements.

B. How to Obtain Hospital Benefits. A claim must be filed with us by the Covered Person or the Hospital. At the time of admission a participating Hospital will usually ask the Covered Person to show his Identification Card for this Contract and will then file the claim with us, or with the local Blue Cross or Blue Shield Plan if care was received in a participating hospital of that other Blue Cross Blue Shield Plan. A non-participating Hospital may choose to bill the Covered Person directly and the Covered Person must then file the claim with us.

C. Nature of Benefits

1. The following patient care services are included if they are customarily provided in the Hospital:

- bed and board, including special diet and nutritional therapy
- general, special, and critical care nursing service, but not private duty nursing service, unless they are employees of the Hospital and their services are included in the Hospital's charges
- facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care, but not the professional services of the surgeons or anesthesiologists unless they are employees of the Hospital and their services are included in the Hospital's charges
- oxygen and other inhalation therapeutic services and supplies
- drugs and medications which are listed and approved for such use in the most recent Physicians' Desk Reference
- sera, biological, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies
- blood, blood products, and blood derivatives and services and equipment related to their administration
- facilities, services, supplies and equipment related to physical and occupational therapy and rehabilitation
- facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including, but not limited to, laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations
- social, psychological and pastoral services
- facilities, services, supplies and equipment related to radiation and nuclear therapy
- facilities, services, supplies and equipment related to Emergency medical care
- any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital except to the extent that they are excluded by this Contract
- chemotherapy
- radiation therapy

2. Benefits are available for accommodations in a semi-private room or ward of a Hospital. If the Covered Person is in a private room at a Hospital, unless we deem it medically necessary, he must pay the difference between the private room charges and the average charges for semi-private rooms at that Hospital. The Covered Person must pay these charges whatever the reason for occupying a private room. The difference between the private room charges and the average charges for semi-private rooms is not applied to the Out-of-Network deductible and coinsurance requirements and as not a covered medical benefits.

3. Mental Health Care and Care for the Treatment of Alcoholism and Substance Abuse.

a. We will pay for up to the number of days listed in the Schedule of Benefits for inpatient care for the treatment of mental health care and up to 7 days of inpatient care for detoxification for alcohol and/or substance abuse per Covered Person per calendar year.

b. Benefits must be received from an In-Network Provider and must be pre-authorized by the Mental and Behavioral Health Care Manager. In case of an emergency, the Covered Person must contact the Mental and Behavioral Care Manager within twenty four (24) hours of admission or as soon as the Covered Person is medically able to do so.

If the Covered Person does not receive the authorization described in this section, a penalty will be imposed as described in Article II.A.

4. Maternity. Hospital inpatient benefits available under the terms of this Contract shall include coverage for a mother and for her newborn for at least forty-eight (48) hours after childbirth for any delivery other than a caesarean section, and for at least ninety-six (96) hours following a caesarean section.

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

Maternity care coverage also shall include, where provided, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

5. Inpatient Mastectomy Stays. Our coverage on inpatient hospital care includes coverage of an inpatient hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of the stay will be determined by the Covered Person and the Covered Person's doctor.

6. Physical Therapy, Physical Medicine or Rehabilitation. We will pay for the number of day's listed in the schedule of benefits for inpatient admissions exclusively for physical therapy, physical medicine or rehabilitation or a combination of these services. The care received must be short term and intended to improve or restore bodily functions within a reasonable and generally predictable period of time. We will not pay for care to maintain the Covered Person at his present level or to prevent further deterioration.

ARTICLE VI – OUTPATIENT HOSPITAL AND AMBULATORY SURGERY BENEFITS

A. Scope of Benefits. Benefits are available for an unlimited number of outpatient visits per calendar year for services described in this Section, except for mammography screening as described below.

Benefits will only be provided for services received in the Emergency room, outpatient department or ambulatory surgery department of a Hospital or in an Ambulatory Surgery Facility. In no event will benefits be provided for services received in a clinic or Facility other than those described above.

These benefits are subject to the MMP requirements described in Article II.

B. Benefits Are Available for the Following:

1. **Emergency Care for Accidental Injury or Sudden and Serious Illness.** Benefits are available for the initial visit to the emergency room for treatment of an emergency as defined below.

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

   The copayment for emergency room services will not be imposed if the Covered Person is admitted to the hospital as an inpatient within 24 hours of receiving emergency room care.

2. **Ambulatory Surgery.** Benefits are available for the Facility charges for covered surgery or procedures the Covered Person's physician recommends be performed in an ambulatory surgery setting.

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

3. **Surgery.** Benefits are available for the facility charges for surgery which includes closed reduction of fractures, dislocations of bones and endoscopies requiring the use of the surgical facilities. It does not include minor surgical procedures which do not require use of the surgical facilities, such as any incisions or punctures of the skin or other tissue. It does not include inoculation, vaccination, collection of blood, drug administration or injection.

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

   a. reservations for a Hospital bed and for an operating room at that Hospital have been made prior to performance of the tests;

   b. the Covered Person's doctor has ordered the tests; and

   c. proper diagnosis and treatment require the tests.

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

5. **Chemotherapy.** Benefits are available in the outpatient department of a Hospital for chemotherapy, including related medications. The medications must be provided by and administered in the Hospital as part of the treatment or by prescription filled by the Hospital pharmacy.

6. **Radiation Therapy.** Benefits are available in the outpatient department of a Hospital for radiation therapy, including related medications. The medications must be provided by the Hospital and administered in the Hospital as part of the treatment or by prescriptions filled by the Hospital pharmacy.

7. **Blood.** Benefits are available for blood or human blood derivatives provided by the Hospital while the Covered Person is receiving benefits for emergency care or ambulatory surgery. This benefit is also available to a Covered Person outside of the Hospital for medically necessary conditions.

8. **Cervical Cancer Screening.** This Contract covers cervical screening in the outpatient department of a Hospital. This includes a pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

9. **Mammography Screening.** Benefits are available for both facility charges in the outpatient department or ambulatory surgery department of a hospital or in an ambulatory surgery facility for mammography screening for occult breast cancer as follows:

    a. Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer.
    b. A single baseline mammogram for covered persons age 35 through age 39 inclusive;
    c. A mammogram every 2 years, or more frequently upon the recommendation of a physician, for covered persons aged 40 through 49 inclusive; and
    d. An annual mammogram for covered persons aged 50 and older.

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

ARTICLE VII - OUTPATIENT TREATMENT OF ALCOHOLISM AND/OR SUBSTANCE ABUSE BENEFITS

A. General Information. Outpatient benefits for the diagnosis and treatment of alcoholism and/or substance abuse are covered for sixty (60) visits per Covered Person per calendar year. Of the sixty (60) visits, up to twenty (20) visits may be used for family counseling. Family members eligible for counseling are those persons covered under the same family Contract that covers the person receiving, or in need of, treatment for alcoholism and/or substance abuse. These family counseling visits are limited to one (1) visit per day and are available even if the person in need of treatment has not yet begun that treatment.

B. Pre-Authorization. In-Network or out-of-network Facilities, whether located in New York State or outside of New York State, must be preauthorized by the mental and behavioral health care manager or be subject to a penalty as stated in Article II.

C. Out-of-Network

1. Facilities that do not have an In-Network Provider agreement must meet the following requirements:

    a. Within New York State the care must be received from an appropriately certified Facility, depending upon the person's primary diagnosis. If the primary diagnosis is alcoholism, the Facility must be certified by the New York State Division of Alcoholism and Alcohol Abuse. If the primary diagnosis is substance abuse, the Facility must be certified by the New York State Division of Substance Abuse Services as a medically supervised Ambulatory Substance Abuse Program.

    b. Outside of New York State

Benefits will be provided for services that are received in a Facility whose alcoholism or substance abuse treatment program has been approved by the Joint Commission on the Accreditation of Healthcare Organizations.

2. Out-of-Network benefits are subject to the deductible and coinsurance set forth in the Schedule of Benefits.

3. The limitation contained in Section K of Article XIII pertaining to Government Hospital Services does not apply to this Article.

ARTICLE VIII - HOME HEALTH CARE BENEFITS

A. Where Home Health Care Benefits Are Available

1. In-Network. In-network benefits must be preauthorized by MMP as set forth in Article II.

We will provide medically necessary in-network benefits for home health care that is provided and billed by a home health care agency which is an In-Network Provider. We will not pay for care or services which are custodial in nature, including assistance in activities of daily living such as bathing, feeding or changing; or services that do not require performance by skilled personnel.

2. Out-of-Network. Out-of-network benefits must be preauthorized by MMP or be subject to a penalty as stated in Article II.

We will provide medically necessary out-of-network benefits for home health care that is provided and billed by a non-participating home health care agency. The home health care agency must be certified under Article thirty-six of the New York State Public Health Law or have comparable certification in another state. We will not pay for care or services which are custodial in nature, including assistance in activities of daily living such as bathing, feeding or changing; or services that do not require performance by skilled personnel.

3. When Home Health Care Benefits Are Available. Health care services received at home from a certified home health care agency or other home health care agency which has a contract with us to provide this service to persons covered under this Contract qualify for coverage under this Contract if:

a. the Covered Person would otherwise have to stay in a Hospital or in a nursing home which qualifies as a "Skilled Nursing Facility" as defined by Medicare; and

b. the Covered Person is under the care of a doctor who certifies the need for home health care and approves a written treatment plan for its provision.

B. What Home Health Care Benefits Are Available. Benefits are available for up to two hundred (200) home health care visits per Covered Person per calendar year for any combination of the services listed below as described in a written treatment plan that is established and approved by the attending doctor and when provided by a home health care agency as described in Section A of this Article. Up to four (4) hours of care a day equals one home health care visit. The services the Covered Person may receive from the home health care agency are:

1. Nursing Care. Intermittent or part-time home nursing care not to exceed twelve (12) hours of care in any day. The care must be provided by a registered nurse or a licensed practical nurse who is under the direct supervision of a registered nurse. If intermittent or part-time care is provided by home health aides, it may not exceed twelve (12) hours of care in any day and must be adjunct to skilled care. Up to four (4) hours of care in any day equals one home care visit. Private duty nursing services are not covered.

2. Rehabilitation Care. Physical, occupational or speech therapy not to exceed twelve (12) hours of care in any day. Up to four (4) hours of care in any day equals one home care visit. Therapy must be restorative

and lead to proven increase in function in a reasonable time. Benefits are not available for maintenance therapy that is designed to prevent deterioration of bodily functions.

3. **Medical Needs.** Supplies, drugs and medications the Covered Person's doctor prescribes and which are provided by the home health care agency. Also included are laboratory services if treatment requires them and if they would have been provided if the Covered Person were in a Hospital or a Skilled Nursing Facility as defined by Medicare.

ARTICLE IX - OUTPATIENT DIALYSIS BENEFITS

A. Where Dialysis Benefits are Available

1. **In Network.** The care must be provided by a Hospital-based or freestanding Facility which has an operating Certificate issued by the New York State Department of Health under Article Twenty-Eight of the New York State Public Health Law and is an In-Network Provider. In addition to an In-Network Agreement, if the care is provided outside of New York State, the Hospital-based or freestanding Facility must have an operating Certificate issued under criteria similar to those used in New York by the state where the care is provided.

2. **Out-of-Network.** If the Hospital-based or freestanding Facility has an appropriate operating Contract but does not have an In-Network Agreement with us or another Blue Cross or Blue Shield Plan, benefits will be Out-of-Network and paid pursuant to Article IV.

B. Hospital - Based or Freestanding Facilities and Home Treatment. If a Covered Person has chronic kidney failure and needs hemodialysis or peritoneal dialysis, benefits are available for these services on an ambulatory or home basis as follows:

1. In a Hospital-based or freestanding Facility, dialysis treatment on a walk-in basis will be covered if the Facility and its program are approved by the appropriate governmental authorities.

2. For home treatment, benefits will be provided for the reasonable rental cost of equipment, as determined by us, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by the Covered Person's doctor. However, coverage does not include any furniture, electrical or other fixtures, plumbing or professional assistance needed to perform the dialysis treatments at home.

3. For these home and Facility-based benefits to be covered, the treatments must be provided, supervised or arranged by the Covered Person's doctor and the Covered Person must be a registered patient of an approved kidney disease treatment center.

4. These benefits for ambulatory and home dialysis continue only until the Covered Person becomes eligible and entitled to benefits for end stage renal disease dialysis benefits under Medicare.

ARTICLE X - HOSPICE BENEFITS

A. Qualification for Benefits. We will provide benefits for up to two hundred and ten (210) days of hospice care once in a Covered Person's lifetime, if a Covered Person has a life expectancy of six (6) months or less. The MMP must pre-certify these benefits as set forth in Article II or a penalty will be applied.

1. **In-Network.** The care must be provided by a hospice which has an operating Contract issued by the New York State Department of Health under Article Forty of the New York State Public Health Law and a Participation Agreement with us or another Blue Cross or Blue Shield Plan. In addition to the Participating Agreement, if the hospice care is provided outside of New York State, the hospice must have an operating Contract issued under criteria similar to those used in New York by the state where the hospice care is provided.

2. **Out-of-Network.** There are no out-of-network benefits under this Contract for this service.

B. Nature of Benefits

The following benefits are available when provided by the hospice organization:

1. Bed patient care in a designated hospice unit or in the hospice area of a Participating Hospital

2. Day care services

3. Home care and outpatient services including:

- intermittent nursing care by a registered nurse, licensed practical nurse or a home health aide, not to exceed twelve (12) hours of care each day
- respiratory therapy
- social services
- laboratory examinations, X-rays, chemotherapy and radiation therapy when required for control of symptoms
- medical supplies and rental of durable medical equipment
- drugs and medications prescribed by the Covered Person's doctor and which are listed and approved for use by the most recent Physicians' Desk Reference. We will not pay for any drug or medication or use of any drug or medication which is, in our judgment, of an experimental nature for the particular diagnosis or condition
- medical care provided by the hospice doctor
- visits for bereavement counseling services for the Covered Person's family during the Covered Person's illness, and until one year after death. Pastoral services are not covered
- transportation between home and Hospital or between home and hospice organization
- respite care not to exceed fourteen (14) hours of care in any week

ARTICLE XI – SKILLED NURSING FACILITY BENEFITS

A. General Information. Benefits are available for Skilled Nursing Care received in a Skilled Nursing Facility, as defined below, as a substitute for all or part of a Covered Person's stay in a Hospital. The MMP must pre-certify these benefits as set forth in Article II or a penalty will be applied.

B. Where We Will Pay for Skilled Nursing Facility Care

1. In-Network benefits. The MMP must preauthorize these benefits as set forth in Article II or a penalty will be applied. These benefits will only be available in a Facility that has a Participating Agreement with us or another Blue Cross or Blue Shield Plan to provide these services to persons covered under this Contract.

2. Out-of-Network. There are no out-of-network benefits available under this Contract.

C. What Benefits are Covered in the Skilled Nursing Facility

1. When the Covered Person is admitted to a Skilled Nursing Facility, we will pay for the same services or items which we would pay for if the Covered Person was an inpatient in a Hospital as described in Article I B(10) of this Contract.

2. "Skilled Nursing Care" is medical or nursing care or rehabilitation services for injured, disabled or sick persons, which is received in a Skilled Nursing Facility, under the direct supervision of a doctor, registered professional nurse, physical therapist or other health care professional, when such care is, in our judgment, medically necessary and appropriate and is approved by us. Care which is primarily assistance with the activities of daily living does not qualify as Skilled Nursing Care.

We will apply the guidelines used by the federal government's Medicare program to determine whether the Covered Person is receiving Skilled Nursing Care.

We will pay for the number of days listed on the schedule of benefits per Covered Person per calendar year in a Skilled Nursing Facility if we determine such care is medically necessary and appropriate.

If the Covered Person does not obtain preauthorization, the penalties listed in Article II will be imposed.

ARTICLE XII - MEDICAL BENEFITS

This part of the Contract covers certain professional medical services listed below. Unless specifically noted otherwise medical services are available in-network subject to the copayment listed in the schedule of benefits, and out of network subject to the deductible and coinsurance. For purposes of this section, medical services mean care provided by a physician, osteopath, optometrist, podiatrist, chiropractor, physical therapist, certified nurse-midwife practicing under qualified medical direction in conjunction with a facility licensed under Article 28 of the Public Health Law of New York State, speech-language pathologist or audiologist, certified acupuncturist, or licensed independent laboratory.

A. Anesthesia Service. Benefits are available for anesthesia service received as part of a covered surgical procedure when rendered by a doctor, but not when rendered by the surgeon or the surgeon's assistant. The Allowed Amount for anesthesia includes consultation by the anesthesiologist before surgery and routine services during and following surgery. Where the hospital or ambulatory surgery center is an In-Network facility, benefits will be provided on an in-network basis for anesthesia services even if the provider rendering the services is not an In-Network provider.

B. Chemotherapy Services. Benefits are available for chemotherapy services when not payable under Article V, Section C or Article VI, Section B(5) of this Contract.

C. Consultation Service. Benefits are available for medically necessary consultations when requested by the attending doctor for advice on an illness or injury which is within the specialist's area of expertise. This service does not include referring the patient from one doctor to another for treatment.

Benefits are not provided for a voluntary second opinion on Surgery or second medical opinion under Section W of this Article in connection with a consultation.

D. Diabetes Education and Management. We will provide self-management education and diet information provided by a physician, certified nurse practitioner, or their staff in connection with medically necessary visits upon the diagnosis of diabetes or a significant change in the patient's symptoms or condition necessitating changes in self-management, or where re-education is medically necessary, as determined by us. Payments for such office visits constitute payment for the entire visit including this education.

Coverage for education is also available when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician or certified nurse practitioner; but such coverage may be limited to a group setting wherever available. Coverage for self-management education and diet education includes home visits when medically necessary.

Benefits are available for the following equipment and supplies when recommended or prescribed by a doctor or other provider authorized to prescribe under Title 8 of the Education Law (Authorized Providers):

1. Blood glucose monitors and blood glucose monitors for the legally blind;

2. Test strips for glucose monitors; visual reading and urine testing strips;

3. Data management systems;

4. Insulin, syringes, injection aids; cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices;

5. Oral agents for controlling blood sugar; and

6. Additionally medically necessary equipment and supplies, as may be required by the New York State Department of Health.

E. Diagnostic Screening Tests. Benefits are available for the following screening tests when they are prescribed by a Covered Person's doctor and the results are interpreted by a licensed Provider performing within the scope of his license. A screening is defined as a test for a certain disease when a Covered Person has no evidence of that disease.

1. Screening for Cervical Cancer. Screening with the Pap smear includes:

a. pelvic examination
b. collection and preparation of a Pap smear
c. laboratory and diagnostic services in connection with examining and evaluating a Pap smear.

2. Screening for Colorectal Cancer

a. Screening for colorectal cancer with the fecal occult blood test is covered annually for Covered Persons aged 40 and over.
b. Screening with sigmoidoscopy is covered once every two years for covered persons aged 40 and over.

3. Screening for Hypercholesterolemia. Screening for serum cholesterol levels is covered once every two years.

4. Screening for Diabetes. Screening for diabetes mellitus is covered for pregnant women at the appropriate stage of pregnancy or for women who are contemplating pregnancy.

5. Allergy Testing and Screening. Benefits are available for diagnosis and treatment of allergies, including test or treatment materials. In-Network Copayments apply to office visits for diagnostic testing but not to in-network office visits for treatment only.

6. Benefits for Prostate Specific Antigen (PSA)

a. In asymptomatic males over age forty (40), one PSA exam every two (2) years is available. An exam is available annually after age seventy-five (75).
b. For all other males, including men with a family history of prostate cancer, age forty (40) and over, one PSA per year is available.

7. Benefits for diagnostic screening described in this Section will not be provided for:

a. Work-site screening services provided by an employer to employees at no cost to the employees.
b. Government health department screening services offered at no charge to the recipient.
c. Services provided in a mobile screening unit (van) unless the services are prescribed by a doctor who is not affiliated with the mobile screening unit.
d. General physical examinations or check-ups.
e. Any other screening test not explicitly referred to in this Section.

F. Diagnostic X-ray and Other Imaging Service. These benefits are only available in-network. Benefits are available for diagnostic X-ray and other imaging services, including interpretation and report for services performed in the doctor's office or outpatient department of a Hospital. Benefits are not available under this Section of the Contract for diagnostic X-ray and other imaging services customarily provided by the Hospital when the Covered Person is an inpatient.

Benefits for MRIs must be pre-certified by the MMP or will be subject to the penalty listed in Article II.

G. Electroconvulsive Therapy Service. Benefits are available for electroconvulsive therapy service for the treatment of mental and behavioral disorders.

H. Home and Office Medical Service. We provide benefits for visits by the Provider in the Covered Person's home or in the Provider's office, when related to an injury or illness, except as otherwise limited in this Contract.

This benefit also includes one physical examination per Covered Person per calendar year, available on an in-network basis only.

I. In-Hospital Medical Service. Non-surgical treatment by the attending doctor while the Covered Person is an inpatient in a Hospital, but not in addition to services covered under the Allowed Amounts for surgery. Also, the professional services covered in Section C of Article V are excluded from coverage under this Section.

We will also cover the service of a physician and other providers, during any period of hospitalization for which we provide coverage in Article V.

J. Laboratory Service. These benefits are only available in-network.

Benefits are available for laboratory services, including interpretation and report at laboratories that are In-Network Providers.

K. Maternity Service. This benefit includes routine care of the mother before and after delivery. The benefit is available in up to three (3) installments, if billed at reasonable intervals: two (2) payments are for prenatal care with the remaining part of our benefit payment for delivery and postpartum care. For this service only, the definition of a "Provider" includes a certified nurse-midwife. A nurse-midwife's services must be provided under the qualified medical direction of a physician and the nurse-midwife must be affiliated with or practicing in conjunction with a licensed Facility.

L. Mammography Screening. Benefits are available for professional services rendered by licensed providers of health care for mammography screenings for occult breast cancer performed in the outpatient department or ambulatory surgery department of a hospital or in an ambulatory surgery facility both facility charges as follows:

1. Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer.
2. A single baseline mammogram for covered persons age 35 through age 39 inclusive;
3. A mammogram every 2 years, or more frequently upon the recommendation of a physician, for covered persons aged 40 through 49 inclusive; and
4. An annual mammogram for covered persons aged 50 and older.

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

M. Mental Health Care. These benefits are only available in-network.

The Mental and Behavioral Health Care Manager must authorize all inpatient and outpatient visits for these services. The Covered Person must call the Mental and Behavioral Health Care Manager to obtain authorization in writing in advance in order to receive benefits. These benefits are subject to the In-Network copayment for each visit listed in the schedule of benefits.

If the Covered Person does not obtain preauthorization, the penalties listed in Article II will be imposed. There are no Out-of-Network benefits.

Professionals Services for mental health are available for each Covered Person per calendar year up to the number of visits listed on the Schedule for Benefits in the provider's office or on an outpatient basis. Benefits are available when these services are performed and billed by psychiatrist, psychologist, or duly certified social worker who are certified pursuant to the requirements of Section 4303(n) of the New York State Insurance Law or comparable legislation outside New York.

N. Prosthetic and Orthotic Appliances and Durable Medical Equipment. These benefits are only available In-Network. Benefits for Durable Medical Equipment, Prosthetics and Orthotic Appliances must be precertified by MMP.

1. Benefits are available for durable medical equipment, and for prosthetic and orthotic appliances that support or replace part or all of a body function or organ as well as the fitting and adjustment of such devices when such devices are prescribed by a Covered Person's doctor and approved by us.
2. Included, for example, are apnea monitors, wheelchairs, hospital-type beds, oxygen equipment, artificial arms, legs and terminal devices (such as hands or hooks, artificial eyes, ears, nose, larynx and external breast prostheses, prescription lenses for Covered Persons lacking an organic lens, rigid or semi-rigid supporting devices and appliances essential to the effective use of an artificial limb, and corrective braces. Non covered items include but are not limited to air conditioners, humidifiers, dehumidifiers, air purifiers, commodes, exercise equipment or swimming pools.
3. Coverage also includes the rental, or purchase where more economical in our judgment, of durable medical equipment which we determine is medically necessary and appropriate for proper therapeutic use. Replacement of durable medical equipment is covered when ordered by the Covered Person's doctor in cases of wear or damage or change in the Covered Person's condition or body structure. Also covered is what we determine to be the reasonable cost of repairs to and maintenance of covered equipment that has been purchased under this Section.
4. Coverage is also available for the medically necessary equipment required by the New York State Health Department for the treatment of diabetes, if recommended or prescribed by a physician or certified nurse practitioner as set forth in Section D of this Article.

O. Professional Ambulance Services. Professional ambulance services are available when used locally to transport a Covered Person to the nearest Hospital in connection with an emergency inpatient admission or emergency outpatient care. Benefits are not available for ambulettes or air ambulances.

We will pay the Allowed Amount for these services. Any difference between the Allowed Amount and the charges is the covered person's responsibility.

P. Physical Therapy Services. These benefits are only available in-network. Benefits for Physical Therapy must be precertified by MMP or will be subject to the penalty listed in Article II.

When prescribed by a doctor, benefits are available for a combined total of the number of visits listed on the schedule of benefits for physical therapy, physical medicine or rehabilitation services provided in the Covered Person's home, Provider's office or on an outpatient basis. The therapy must improve or restore bodily functions within a reasonable and predictable period of time. This benefit is subject to the copayment listed in the schedule of benefits.

Benefits for inpatient physical medicine and rehabilitation benefits are available for an additional number of days listed on the schedule of benefits per calendar year for professional services rendered by a licensed Provider while the Covered Person is an inpatient.

Therapy must be restorative and lead to proven increase in function in a reasonable time. Benefits are not provided for maintenance therapy that is designed to prevent deterioration of bodily functions.

Q. Chiropractic Care. We will pay for services rendered 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. We will not pay for any visits which we determine, in our sole judgment, were not medically necessary.

R. Surgical Service

1. Benefits are available for surgical service, including operating and cutting procedures for the treatment of a sickness or injury and closed reduction of fractures and dislocation of bones, endoscopies, incisions or punctures of the skin.

   It does not include inoculation, vaccination, drug administration or injection. Benefits for routine care related to surgery are included in the Allowed Amount for the type of procedure received, and are not available under other provisions of this Contract.

2. Sometimes 2 or more surgical procedures can be performed during the same operation. When they are done through the same incision, we pay only for 1 procedure -- the one with the highest allowance. If they are done through different incisions, we will pay the Allowed Amount for the procedure with the highest allowance and 50% percent of the Allowed Amount for the other procedure(s).

3. Coverage of surgical services includes all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We will also pay for reconstructive surgical procedures on the other breast to produce a symmetrical appearance.

S. Surgical Assistant Service. Benefits for the surgical assistant services are available to help the surgeon if:

1. the surgical "assistant" is not an employee of the Hospital; and
2. the operation is performed in a Hospital requires an assistant, and the Hospital has no doctor who is an employee available to help the surgeon.
3. Benefits will be provided on an in-network basis if the surgeon is an in-network provider, even if the assistant surgeon is not a participating provider.

T. Supplies. Benefits are available, when medically necessary, for disposable medical supplies when prescribed by a Covered Person's doctor and precertified by us, such as ostomy supplies, catheters, oxygen and needles.

Coverage is also available for the medically necessary supplies required by the New York State Health Department for the treatment of diabetes, if recommended or prescribed by a physician or certified nurse practitioner as set forth in Section D of this Article.

U. Speech, Vision and Occupational Therapies. These benefits are only available in-network. Benefits for these Therapies must be precertified by MMP or will be subject to the penalty listed in Article II.

1. Benefits are available for a combined total of the number of visits listed on the schedule of benefits per calendar year for any combination of speech, vision, or occupational therapy furnished by skilled medical personnel in the outpatient department of a hospital, provider's office or the Covered Person's home.

2. Benefits will be paid for speech/language pathology or audiology services performed by a licensed speech-language pathologist or audiologist, if performed pursuant to medical orders or a similar or related service of a physician. Coverage will not be provided for any tests, evaluation or diagnoses which has already been provided by or through a physician within 12 months of the referral or order from the physician.

V. Well Child Care. Benefits for primary and preventive care services are provided as follows for an eligible dependent child from birth until the child's nineteenth (19) birthday, when rendered by or under the supervision of a physician, nurse, or nurse practitioner.

- Newborn baby - one (1) in-Hospital examination at birth
- birth to 1 year of age - 6 visits
- 1 through 2 years of age - 3 visits
- 3 through 6 years of age - 4 visits
- 7 years of age until 19th birthday - 6 visits.

During these visits coverage will be provided for services in accordance with the prevailing clinical standards of the American Academy of Pediatrics. Covered services include a physical examination, medical history, developmental assessment, anticipatory guidance, laboratory tests ordered at the visit and performed in the office or in the laboratory and necessary immunizations as listed below:

Immunizations include DPT (diphtheria, tetanus and pertussis), polio, MMR (measles, mumps and rubella), hepatitis B, hemophilus, tetanus-diphtheria, pneumococcal, meningococcal, and tetramune, and varicella (chicken pox).

Additional immunizations may be covered as determined by the New York State Superintendent of Insurance in consultation with the Commissioner of Health.

The In-Network Copayment will not be imposed on this benefit.

W. Voluntary Second Opinion on Surgery and Second Medical Opinion.

a. If the Covered Person wishes to obtain a voluntary second surgical opinion we will pay for a second opinion on proposed surgery at no cost to the Covered Person, when all of the following conditions are met:

   1. the Covered Person's doctor recommends that surgery be performed;
   2. the second surgical opinion referral must be obtained through the Medical Management Program. To obtain a referral, the Covered Person should contact our Medical Management Program at the telephone number listed on the Identification Card.
   3. the specialist who renders the second opinion on surgery does not also perform the surgery on the Covered Person for which the second opinion was obtained.

      We will provide a choice of surgical specialists who have an agreement with us to provide this service. The second opinion includes the costs of diagnostic X-ray and laboratory services if ordered by the specialist. If the need for surgery is not confirmed, we will provide a third opinion if requested, when arranged by the Medical Management Program.

      The Covered Person is not required to satisfy the Out-of-Network deductible and coinsurance requirement in connection with the second opinion on surgery when all of the conditions of this Section are satisfied.

b. Second Medical Opinions. We will pay for an office visit and related diagnostic tests provided by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. We will also pay for a second medical opinion concerning any recommendation of a course of treatment for cancer. If your in-network attending physician provides a written referral to a non-participating specialist, in-network benefits subject to the copayment listed in the schedule of benefits, will be available as if the services had been provided by a participating appropriate specialist. A second medical opinion may also be obtained without a written referral from a non-participating specialist, and the Covered Person will be entitled to the out-of-network benefits available under the terms of the contract.

X. Well-Woman Care. Benefits are available each calendar year for each Covered Person for

1. Examinations for primary and preventive obstetric and gynecological services;
2. Care related to pregnancy

3. Gynecological or obstetrical services required as a result of each primary and preventive examination, or as a result of an acute gynecological condition.

Y. Hearing Examinations. We will pay for medically necessary hearing examinations, but not for hearing aids, including examinations for, or fitting of, hearing aids.

Z. X-ray, Radium and Radionuclide Therapy. Benefits are available for X-ray, radium and radionuclide therapy services in the doctor's office.

ARTICLE XIII - LIMITATIONS AND EXCLUSIONS

This Article explains the limits on benefits and sets forth other services or items that are excluded from coverage under this Contract. Other descriptions of limitations on benefits or excluded services or items may also be discussed in other Articles of this Contract. A Covered Person should review this Article before filing for benefits to avoid submitting a claim for services or items that are not covered under this Contract. When Limitations and Exclusions apply to a Hospital stay or a part of a day of hospitalization, no benefits are available for any part of the Hospital day(s) to which they are applied.

A. Medically Unnecessary Care. We will not provide benefits for any treatment, service or supply which, in our judgment, is not Medically Necessary as defined in Article I.

B. Unnecessary or Inappropriate Services. No benefits are available for any services or items or any portion of a stay in a Facility covered by this Contract that, in our judgment, are not needed for proper medical care. If services or items or any portion of a stay are provided that cost more than other types of care, which, in our judgment, are equally or more beneficial, benefits may be limited to the cost of the less expensive type of care. For example, we will not pay for an inpatient admission for surgery if, in our judgment, the surgery could have been performed in an ambulatory surgery Facility. We will not provide any benefits for any day or part of any day that the Covered Person is out of the Hospital. Nor will we provide any benefits for any day when, in our judgment, inpatient care was not necessary.

C. Benefits for Medicare Eligibles Who Are Covered Under This Contract

1. When the Group has 20 or more employees, any active employee or spouse of an active employee who becomes or remains a member of the Group covered by this Contract after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Contract as primary, unless such Covered Person elects Medicare as his primary coverage. However, the Group must notify us of the Covered Person's election and pay the appropriate premiums. Any Covered Person who elects Medicare as primary shall not be eligible for coverage under this Contract as of the date of such election.

2. If your Group has 100 or more employees or your Group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or dependent child of an active employee who becomes or remains a member of your Group covered by this Contract after becoming eligible for Medicare due to disability will receive the benefits of this Contract as primary, unless such Covered Person elects Medicare as his primary coverage. However, you must notify us of the Covered Person's election and pay the appropriate premiums. Any Covered Person who elects Medicare as primary shall not be eligible for coverage under this Contract as of the date of such election.

3. Any Covered Persons who are not subject to subsections 1 and 2 of this Section and who are Medicare eligible will receive the benefits of this Contract reduced by any benefits available under Medicare. This applies even if the Covered Person fails to enroll in Medicare or does not claim the benefits available under Medicare.

D. Treatments, Procedures, Hospitalization, Drugs, Biological Products or Medical Devices Which Are Experimental or Investigational. Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration, we will not cover any treatment, procedure, drug, biological product or medical device

(hereinafter "technology") or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational, unless otherwise recommended by an External Appeal Agent. Experimental or investigational means that the technology is:

1. not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition; or

2. not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the Covered Person's particular condition.

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

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the Covered Person's particular condition.

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

1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.

2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Diagnostic Services. We will not cover an inpatient Hospital stay or any part of it that is primarily for diagnosis unless the diagnostic services are performed in connection with specific symptoms which, if not treated immediately on an inpatient basis, could reasonably result in deterioration of the condition so as to cause serious impairment to the Covered Person's bodily functions or jeopardy to his life and the services cannot be safely received, in our judgment, outside a Hospital.

F. Cosmetic Surgery. No benefits are provided for elective cosmetic surgery or for any complications arising from such surgery, or any Hospitalization in connection with such surgery or its complications. However, benefits are available for reconstructive surgery if it is necessary to treat an infection or injury, provided that such infection or injury does not arise from cosmetic surgery. With respect to a covered child, benefits are available for cosmetic surgery to treat a functional defect which is caused by a congenital disease.

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

H. Foot Treatment. There are no benefits for care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet. However, capsular or bone surgery related to bunions and hammertoes will be covered when medically necessary. Orthotics for treatment of routine conditions of the feet are excluded except that routine foot care and orthotics are covered if associated with disease affecting the lower limbs, such as severe diabetes, which requires care of a podiatrist or a physician.

I. Eyeglasses. Eyeglasses, including the fitting of, or examination of the eye for, glasses or contact lenses are not covered except when medically necessary and appropriate, in our judgment, following cataract surgery.

J. Workers' Compensation, No-Fault Automobile Insurance and Similar Legislation. No benefits will be provided for services covered in whole or in part under a Workers' Compensation Act, the Federal Employers' Liability Act, the Longshoremen's and Harbor Workers' Compensation Act, Jones Act or similar law, and/or the mandatory portion of a no-fault automobile insurance policy unless and until the Covered Person has exhausted all of the benefits available under these laws. This applies even if (1) the Covered Person does not claim benefits under the above laws or policies or (2) after any of the above benefits are paid, the Covered Person must repay them because he recovers that money in a lawsuit or other proceeding.

K. Government Hospital Services. No benefits are provided for services received in a government or a public benefit corporation Hospital unless we have a Participation Agreement or special agreement with that Hospital (and then only for the specific services to which the special agreement applies). However, this exclusion shall not apply to United States Veteran's Administration or Department of Defense Hospitals except for services in connection with a service-related disability. In addition, if a Covered Person is hospitalized in a government or public benefit corporation Hospital due to an Emergency, benefits are provided as described in Article V, Section A, until such time as the Covered Person can, in our judgment, be safely transferred to a Participating Hospital.

L. Hearing Aids. Hearing aids, including examinations for, or fitting of, the hearing aid, are not covered.

M. Services Covered Under Government Programs. No benefits are provided for services the Covered Person is eligible to receive under any federal, state, county or municipal law or the laws of any other country except for Medicaid and as described in Sections C and K of this Article.

N. Non-Acute or Chronic Hospital Care. There are no benefits for any part of a Hospital stay that is primarily custodial or for a rest cure or for convalescent or sanitarium type care or care that is not curative or restorative and is not a form of medical treatment. There is no coverage for care in a Hospital, or in a separate division of a Hospital, where half or more of the days of care provided by that Hospital or that separate division of the Hospital are during stays of more than ninety (90) days in length.

O. Services Usually Given Without Charge. We will not cover any service if it is usually provided without charge. For example, when a Provider does not usually collect payment in the absence of insurance coverage, no benefits are provided. This applies even if charges are billed. We will not cover any service provided by an immediate family member.

P. War. No benefits are provided for any injury or illness received as a result of war, declared or undeclared, or any act of war.

Q. Travel. No benefits are provided for travel expenses, even if associated with treatment recommended by a doctor.

R. Limit on Payment. We will not pay an amount that is more than a Provider charged for covered care or that is more than the Customary Charges, nor will we credit such an amount toward the deductible or coinsurance.

S. Services at Home. We will not cover any services in the Covered Person's home, except for those services which are specifically noted in this Contract as available in the home, or which, in our judgment, are medically necessary and appropriate as a result of an Emergency.

T. Services by Unlicensed Providers. Any services provided by an unlicensed Provider or services that are outside the scope of the license of the licensed Provider who provided them are not covered.

U. Services by Employees of Facilities. There are no benefits for services performed by staff employed by a Hospital or institution where the Covered Person receives care.

V. Services for Private Duty Nursing. We will not cover private duty nursing services.

W. Independent Contractors. The relationship between us and Hospitals or Facilities or Providers is that of independent contractors. Nothing in this Contract shall be deemed to create between us and any Hospital, Facility or Provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. We shall not be liable in any lawsuit claim or demand for damages incurred or injuries sustained by a Covered Person resulting from care received in a Hospital, Facility or from a Provider.

X. Mental and Behavioral Care. There are no Out-of-Network benefits under this Contract for the inpatient treatment of mental and behavioral disorders or alcohol detoxification, and rehabilitation.

Y. Prescription Drugs. There are no benefits under this Contract for prescription drugs, over-the-counter drugs which do not require a prescription, self-administered injectables, vitamins, appetite suppressants, oral contraceptives or any other type of medication unless specifically stated in this Contract.

Z. Assisted Reproductive Technologies. There are no benefits under this Contract for reversal of sterilization and assisted reproductive technologies including but not limited to, in-vitro fertilization, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.

AA. Services Provided Pursuant to a Prohibited Referral. We will not pay for pharmacy services, clinical laboratory services, radiation therapy, or X-ray or imaging services furnished by any Provider pursuant to a referral prohibited by §238-a of the New York State Public Health Law. Generally, §238-a prohibits physicians and other health care practitioners from making referrals for clinical laboratory services, X-ray and imaging services, or pharmacy services to a Provider or Facility in which the referring physician or practitioner of an immediate family member has a financial interest or relationship.

BB. Pre-Existing Condition Limitation. We will not pay for any pre-existing conditions until the Covered Person has been enrolled under this Certificate for at least 11 consecutive months. A pre-existing condition is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received with the six month period ending on the enrollment date under this Contract of Certificate. For purposes of this section, “enrollment date” means the first day of the Covered Person’s coverage under this Contract or, if earlier, the first day of any waiting period that must pass before the Covered Person is eligible to be covered for benefits under this Contract.

Genetic information will not be treated as a pre-existing condition unless the Covered Person has been diagnosed with a condition related to such information. This exclusion does not apply:

A. If, on the last day of the 30 day period beginning on the date of birth, the Covered Person is covered under Creditable Coverage as defined below.

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

C. In the case of pregnancy.

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

"Creditable Coverage" means coverage under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or B of title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under chapter 89 of title 5, United States Code;
9. A public health plan (as defined in regulations);
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

In determining whether this pre-existing condition provision applies, we will credit the time the Covered Person was previously covered under Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the enrollment date under this Contract. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective will also be credited.

This exclusion does not apply to groups of 300 or more persons as required by Insurance Department regulation.

CC. Custodial Care. We will not pay for care or services which are custodial in nature, including assistance in activities of daily living such as bathing, feeding or changing; or services that do not require performance by skilled personnel.

DD. Benefits will not be provided for surgery and/or treatment for gender change.

ARTICLE XIV - COORDINATION OF BENEFITS

A. Applicability. This Article applies only to Covered Persons who also have group health coverage with another "plan". For the purposes of this Article only, the word "plan" is defined in Section B below. When a Covered Person receives a covered service or has a covered expense, we will coordinate benefit payments with any payment made under the other plan. The Primary Plan will pay its full benefit and the other will pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This prevents duplicate payments and overpayments.

B. Definition of "Plan". "Plan" is another group health program with which we will coordinate benefits. The term "plan" includes:

1. Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the policyholder (the school or organization) pays the premiums.

2. Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

3. Hospital, medical and surgical benefits coverage of Medicare or a governmental plan offered, required or provided by law, except Medicaid. The term "plan" does not include any plan whose benefits are by law excess to any private benefits coverage.

C. Rules to Determine Order Of Payment. The first of the rules listed below in paragraphs 1-6 that applies will determine which plan shall 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 Covered Person receiving benefits is the Member and is only covered as a dependent under the other plan, this Contract will be primary.

3. If a dependent 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 shall be primary. If both parents have the same birthday, the plan which covered the parent longer shall 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 father's plan shall be primary.

4. If a dependent child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents which establishes financial responsibility for the child's health care expenses:

   a. the plan of the parent who has custody (the custodial parent) shall be primary;
   b. if the custodial parent has remarried, and the child is also covered as a dependent under the step-parent's plan, the custodial parent's plan shall pay first, the step-parent's plan second and the non-custodial parent's plan third.
   c. If a court decree between the parents specifies which parent is to be responsible for the child's health care expenses, then that parent's plan shall be primary if that plan has actual knowledge of that decree.

5. If the Covered Person is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the dependent of such an active employee or member, and is also covered under another plan as a laid-off or retired employee or as the dependent of such a laid-off or retired employee or member, the plan which covers him as an active employee, or as the dependent of such an active employee or member, shall be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

6. If none of the above rules determines which plan shall be primary, the plan which covered the Covered Person for the longer period of time shall be primary.

D. Effects of Coordination. When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits paid or provided by the Primary Plan(s) and this Plan during a claim determination period will not exceed the total allowable expenses. Also, the amount we pay or provide will not be more than the amount we would pay or provide if we were primary.

Allowable expense is the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

The claim determination period is the calendar year over which allowable expenses are compared with total benefits payable in the absence of COB, to determine: 1) whether overinsurance exists; and 2) how much each plan will pay or provide.

E. Private Room Charges. Regardless of whether this Contract is primary or secondary, we will not pay or provide benefits for the difference between the cost of a private Hospital room and the cost of a semi-private Hospital room when private room is not medically necessary.

F. Right to Receive and Release Necessary Information. We may release or obtain information which we need to coordinate benefits as we have described. We need not tell any person or obtain anyone's consent to do this except as required by Article XXV (25) of the New York General Business Law. We are not responsible to anyone for releasing or obtaining this information. The Covered Person must give us any needed information in the time frame we request, and if he does not, we may deny the claims for which the information was needed.

G. Payments to Other Plans. We may pay any other plan any amount which it paid for services rendered to a Covered Person if we decide that we should have covered those services. These payments are the same amounts we would have paid to the Covered Person or Provider under this Contract.

H. Our Right to Recover Overpayment. If we made a payment even though the Covered Person had coverage under another plan, the Covered Person agrees to pay us any amount by which we should have reduced our payment. Also, we may recover any overpayment from the other plan or Provider receiving payment and the Covered Person agrees to sign all documents necessary to help us recover any overpayment.

I. Coordination with "Always Excess," "Always Secondary" or "Non-Complying" Plans. We will coordinate benefits with plans, whether insured or self insured, which provide benefits which are stated to be always excess or always secondary or use order of benefit determination rules which are inconsistent with those described above ("non-complying plans") in the following manner:

a. If this Contract is primary, as defined in this Section, we will pay or provide benefits first;
b. If this Contract is secondary, as defined in this Section, we will pay only the amount we would pay or provide as the secondary insurer;
c. If we request information from a non-complying plan and do not receive it within thirty (30) days of our request, we can calculate the amount we should pay or provide on the assumption that the non-complying Plan and this Contract provide identical benefits. When the information requested is received, we will make any necessary adjustments.

ARTICLE XV - TERMINATION

A. Termination and Nonrenewal. The group can terminate this contract at any time by giving us 60 days prior written notice. Unless the group terminates the contract, the contract will be renewed and continued in force, except that Empire may nonrenew or discontinue coverage under such a group contract based only on one or more of the following:

a. the group contract holder or participating entity has failed to pay premiums or contributions in accordance with the terms of the policy or Empire has not received timely premium payments.

b. The group contract holder or participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

c. The group contract holder has failed to comply with the material plan provision relating to employer contribution or group participation rules, as permitted under section four thousand two hundred thirty-five of the Insurance Law of the State of New York.

d. Empire ceases to offer group or blanket policies in a market in accordance with this provision.

In any case in which Empire elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued only if:

i. Empire provides written notice to the superintendent and to each group contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;

ii. All hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed.

e. The contract holder ceases to meet the requirements for a group under section four thousand two hundred thirty-five of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the policy is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.

f. Where we offer a group contract in a market through a network plan, there is no longer any member in connection with such plan who lives, resides or works in our service area.

g. Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

h. In any case where Empire decides to discontinue offering a particular class of group contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class will be discontinued if:

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

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

B. When a Covered Person Who Is Terminated May Convert This Contract. If Group coverage ends for any of the reasons below, a Covered Person may purchase an individual direct payment contract.

a. A Covered Person no longer qualifies as a member of the family under this Contract because:

i. he is a child who marries;
ii. his coverage terminates pursuant to Article I, Section D(3)(c);
iii. he is divorced from the Member or his marriage to the Member is annulled;
iv. the Member dies; or
v. he was covered as an incapacitated child and is no longer incapacitated.

b. The Member is an active employee or member or the spouse of an active employee or member and has elected Medicare Coverage as his primary coverage.

c. The Member no longer qualifies as a member of the Group.

d. The Group no longer meets our underwriting standards.

e. The Group terminates this Contract and does not offer replacement coverage whether insured or uninsured to the members of the Group.

IMPORTANT: The group should advise us before a Covered Person loses eligibility for coverage. This way, we can offer a conversion contract with no interruption in coverage. This means that the person need not fulfill a new waiting period for certain benefits. If there is an interruption in coverage, a new waiting period may be required under the new contract.

C. How to Convert Coverage under This Contract. If the insurance on an employee or member insured under the group policy ceases because of termination of: (i) employment or of membership in the class or classes eligible for coverage under the policy; or (ii) the policy is terminated for any reason whatsoever, unless the contract holder has replaced the group policy with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group policy for at least three months shall be entitled to have issued to him by Empire without evidence of insurability upon application made to the insurer within forty-five days after such termination, and payment of the quarterly premium, an individual policy of insurance that is available to direct pay and subscribers at that time and has benefits that are most comparable to the benefits of this contract. The conversion privilege afforded herein shall also be available: (A) upon the divorce or annulment of the marriage of a member, to the divorced spouse or former spouse of such member, (B) upon the death of the member, to the surviving spouse and other dependents covered under the contract, and (C) to a dependent if no longer within the definition in the contract.

Notice of such conversion privilege and its duration shall be given by the contract holder to each Member upon termination of his group coverage. Each member in the insured group, but not his dependents, shall be given written notice of such conversion privilege within fifteen days after the date of termination of coverage under the group contract, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of coverage under the group contract the time allowed for the exercise of such conversion privilege shall be extended for forty-five days after the giving of such notice. If such notice is not given within ninety days after the date of termination of coverage under the group contract the time allowed for the exercise of such conversion privilege shall expire at the end of such ninety days.

D. Termination - When a Covered Person May Not Convert Coverage under this Contract. A Covered Person may not convert coverage under this Contract if:

1. the Covered person fraudulently filed the Notice of Election and was never an eligible member of the Group;

2. the Group Contract has been replaced with similar and continuous coverage for the same group whether insured or self-insured; or

3. such other reasons, including, but not limited to, the filing of false or improper claims, as the Superintendent of Insurance may approve upon not less than one month's prior written notice.

E. When a Covered Person May Continue Group Coverage After Losing Eligibility in the Group. Under certain circumstances, described below, Covered Persons who would otherwise lose coverage under the eligibility provision of their group plan may retain group coverage as "Continued Coverage Beneficiaries" for limited periods of time noted below under Section 4305(e) of the New York State Insurance Law (State Law), or under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) if applicable.

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

Such eighteen (18) month period of coverage may be extended for up to an additional eleven (11) months or a total of twenty-nine (29) months if the Covered Person is determined to be disabled under the Social Security Act at the time of termination of employment or reduction of hours or at any time during the first 60 days of continuation of coverage. Such Covered Person must provide notice to the Group Health Plan Administrator before the end of the initial eighteen (18) months and within sixty (60) days of such

disability determination. If the Covered Person is determined to be no longer disabled under the Social Security Act, such Covered Person must provide notice to the Group Health Plan Administrator within thirty (30) days of such determination.

a. When a Covered Person's employment terminates for any reason, other than gross misconduct, or the number of hours he works is reduced so that he is no longer eligible for group coverage, continued coverage under COBRA is available for up to eighteen (18) months. (This may not apply to certain non-resident aliens with United States source-earned income of up to three thousand dollars $3,000).

b. When a Covered Person is no longer eligible for group coverage under this Contract or Contract because (i) he no longer qualifies for coverage under the definition of "Children," (ii) the Member dies, (iii) the Member is divorced or legally separated from his spouse, or (iv) the Member becomes entitled to Medicare, continued coverage is available for the dependents under COBRA for up to thirty-six (36) months.

c. If a Continued Coverage Beneficiary experiences one of the events listed in paragraph (b) above during his eighteen (18) month period of continued coverage, he may receive an additional eighteen (18) months of continued coverage for a maximum of thirty-six (36) months of continued coverage. Such additional coverage is measured from the date of the event for which he first became entitled to continued coverage, as set forth in paragraph (a) above. Under certain circumstances, a Continued Coverage Beneficiary is entitled to thirty-six (36) months of continued coverage as measured from the date of Medicare entitlement. This could result in a total of more than thirty-six (36) months of continued coverage.

d. Continued coverage may be available under this Contract or Contract because the Member who is a retiree loses coverage due to the Group's commencement of proceedings under Title 11 of the Federal Bankruptcy law. Continuation Coverage for such retirees and their surviving spouses can be lifetime, and can extend up to thirty-six (36) months after the death of the retiree for the surviving spouse and dependent children. Termination of continued coverage may be subject to special requirements.

2. Notification Requirements Under COBRA

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

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

4. Payment of Premiums

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

5. Termination of Continued Coverage.

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

a. The Continued Coverage Beneficiary fails to pay the premiums when due.
b. The Group no longer provides group health insurance to any of its employees or members.
c. The Continued Coverage Beneficiary becomes entitled to Medicare.

Under COBRA, coverage generally ends at the earliest of the following:

a. when the Continued Coverage Beneficiary becomes covered under another group contract, unless such other group contract affecting the Continued Coverage Beneficiary has any exclusion or limitation with respect to any pre-existing condition, in which case continued coverage ends at the earliest of:

   i. when the pre-existing limitation period of the other group contract has expired, or
   ii. the applicable eighteenth (18th), twenty-ninth (29th) or thirty-sixth (36th) month of coverage has expired, or

b. eighteen (18) months after the date of one of the events described in paragraph 1(a), or

c. twenty-nine (29) months after the date of one of the events described in paragraph 1(a), unless sooner terminated because the Continued Coverage Beneficiary is determined to be no longer disabled under the Social Security Act, or

d. thirty-six (36) months after the date of one (1) of the events described in paragraph 1(b) or 1(c).

6. The Right to Convert Coverage When Continued Coverage Ends. When continued coverage ends, a Continued Coverage Beneficiary may convert his coverage according to the terms of the Article describing the termination and conversion provisions of this Contract.

7. Under New York State Law. If a Covered Person is not entitled to temporary continuation of coverage under COBRA (for example because the employer has less than twenty (20) employees), the Covered Person may be entitled to continuation of coverage under the provisions of the New York State Insurance Law. The Covered Person should call or write the employer or us to find out if he or she is entitled to temporary continuation of coverage under the New York State Insurance law.

F. Veterans' Supplementary Continuation and Conversion. If the Group's plan qualifies as an employer group health plan subject to federal continuation of coverage provision of COBRA as described elsewhere in this Contract, the supplementary continuation and conversion right described in this Section do not apply.

If a Member who is a member of a reserve component of the armed forces of the United States, including the National Guard, enters upon active duty and the group does not voluntarily maintain coverage for such Member, coverage shall be suspended unless the Member elects in writing, within 60 days of being ordered to active duty, to continue coverage under this Contract for the Member and eligible dependents. Such continued coverage shall not be subject to evidence of insurability. The Member must pay the group the required group-rate premium in advance, but not more frequently than once a month.

Veterans' supplementary continuation shall not be available to any person who is, or could be, covered by Medicare or any other group coverage. Coverage available to active duty members of the armed forces shall not be considered group coverage for the purposes of this paragraph.

In the event that the Member is reemployed or restored to participation in the Group upon return to civilian status after the period of continuation of coverage or suspension, the Member shall be entitled to resume coverage under this Contract for the Member and eligible dependents. If coverage has been suspended, resumed coverage will be retroactive to the date of termination of active duty. No exclusion or waiting period shall be imposed in connection with resumed coverage except regarding:

1. a condition that arose during the period of active duty and that has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty; or

2. a waiting period imposed that had not been completed prior to the period of suspension. The sum of the waiting periods imposed prior and subsequent to the suspension shall not exceed eleven months.

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

ARTICLE XVI - SUBMISSION OF CLAIMS

A claim must be filed with us by the Covered Person or the Hospital or other Provider of covered services. At the time of admission, a Participating Hospital will usually ask the Covered Person to show his Identification Card for this Contract and will then file the claim with us. A Non-Participating Hospital may arrange to file the claim with us. An Out-of-Network Provider may also bill the Covered Person directly and the Covered Person must then file the claim with us. If the Covered Person would like us to process a claim for care, the Covered Person must give us, or arrange for us to receive, the following items, which shall be in English or submitted to us with a translation into English:

A. A completed Health Insurance Claim Form including necessary reports and records. WE MUST RECEIVE THIS FORM WITHIN 18 MONTHS OF THE DATE THAT CARE WAS PROVIDED OR THE CLAIM WILL NOT BE PAID BY US. These forms can be obtained from us or the Provider. The Member identification number must be reported as it appears on the Member's Identification Card and all questions on the Health Insurance Claim Form must be answered. Otherwise, we will return the form for completion.

B. In addition to the claim form, we may request that the Covered Person provide written statements about eligibility or the services received, itemized bills from a Hospital/Facility or other Provider, details of the treatment or advice the Covered Person received, details of other insurance coverage, or any other information or materials that, in our judgment, are necessary to process the claim. Benefits payable under this policy will be payable not more than forty-five days after receipt of a claim, except in a case where our obligation to pay a claim submitted is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Insurance Department that such claim was submitted fraudulently.

C. If the claim is for ambulances or durable medical equipment, the Covered Person must attach to the claim form the Provider's original itemized bills, which must include the following information:

1. Ambulance bills - the date of service, and reason for service, the total mileage traveled, the charge, and a copy of the required doctor's authorization for the ambulance. See Article XII, Section O.

2. Supplies and Durable Medical Equipment and Orthotics - a copy of the doctor's authorization which must include a description of the item and an explanation of the Medical necessity for the specific item. See Article XII, Sections N and T.

D. Who Receives Payment Under This Contract. Payments under this policy for services provided by participating providers will be made directly to the participating provider. If the Covered Person receives services from non-participating providers, we reserve the right to pay either the Covered Person or the Provider.

E. Recovery of Overpayments. On occasion a payment will be made when a Covered Person is not covered, for a service which is not covered, or which is more than is due under the Contract. When this happens we will explain the problem to the Covered Person and he must return to us within sixty (60) days the amount of the overpayment.

ARTICLE XVII - DISPUTES UNDER THIS CONTRACT

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

Under ERISA, if we deny a claim, wholly or partly, the Covered Person may appeal our decision. The Covered Person will be given written notice of why the claim was denied, and of his right to appeal the decision. Then the Covered Person has 60 days to appeal our decision. The Covered Person (or his authorized representative) may submit a written request for review. The Covered Person may ask for a review of pertinent documents, and the Covered Person may also submit a written statement of issues and comments. The claim will be reviewed and we will make a decision within sixty 60 days after the appeal is received. If special circumstances require an extension of time, the extension will not exceed 120 days after the appeal is received. The decision will be in writing, containing specific reasons for the decision.

Empire's time to respond to any appeals by Covered Persons which involve medical necessity or that are made in connection with the Medical Management provisions in Article II of this contract are governed by the more restrictive requirements of section C. of Article II, and not the times to respond referred to in this section. You also may have the right to request a review by an External Appeal Agent, as described in Article II C.

B. Choice of Law. This Contract has been issued in New York State to a Group located in New York State. In any dispute between us and the Group or any Covered Person, New York or federal law, as appropriate, shall be applied to determine the group's rights, the rights of Covered Persons, the rights of Providers and our rights.

C. Time to Bring Legal Action. The Covered Person must start any lawsuit against us under this Contract within two years from the date the Covered Person receives the service for which payment is sought. However, a lawsuit may not be started under this Contract until 60 days after the claim has been filed with us.

ARTICLE XVIII - MISCELLANEOUS

A. Furnishing Information and Audit. The Group and Covered Persons agree to furnish promptly to us all information and records which we may require from time to time to perform our obligations under this Contract. The Group agrees that upon reasonable notice it will make available to us at the Group's New York office and we may audit and make copies of any and all records relating to Group enrollment.

B. Enrollment. The Group further agrees to develop and maintain complete and accurate payroll records, as well as any other records, of the names, addresses, ages and social security numbers of all Covered Persons, and any other information required to confirm their eligibility for services under this Contract. The Group agrees to provide us with the Notice of Election including the names, addresses, ages, and social security numbers of any Covered Persons and to advise us in writing, on a monthly basis, of any Covered Persons to be added to or subtracted from our list of Covered Persons. If the Group fails to so advise us, the Group will be responsible for the cost of any claims paid by us as a result of such failure.

C. This Contract Does Not Change a Provider's Usual Procedures. This Contract does not change the relationship between a patient and Provider and it does not force a Provider to accept a Covered Person as a patient.

Usual Hospital rules apply to the services Covered Persons receive. We do not guarantee admission to any Hospital or that any particular service or accommodation will be available.

D. Covered Persons's Release to Us of Medical Records and Other Information We May Need and Authorization for Us to Disclose Information. Providers and other entities often have information we need to determine eligibility for benefits under this Contract. Some of these Providers and entities are Hospitals, doctors, health care Providers, clinics, other Providers of health care, other insurers, payors of health claims, other medical or medically related Facilities or government agencies. As a condition of coverage under this Contract, each Covered Person grants access to us or our designee and permits us to use for our purposes all medical records and other information pertaining to any health-related services which he may receive or may have received in the past. Further, each Covered Person hereby authorizes all the Providers and entities referred to above to furnish to us any and all records and other information pertaining to his eligibility under this Contract, his medical history, services rendered, and treatment received or payments made so we may review, investigate and evaluate all claims. If necessary, at any time requested by us, a Covered Person will provide us with a signed authorization to obtain records, as set forth above to review the level of care provided to him.

Each Covered Person also authorizes us to disclose to a Hospital or health care service plan, self-insurer or insurer, any medical information obtained or benefits paid by us if such disclosures are necessary to allow the processing of any claim.

Each Covered Person also authorizes us to make such disclosures to the Group for purposes of utilization review or audit and to make such other disclosures as may be permitted or required by law.

Each Covered Person also authorizes the Health Care Financing Administration and Medicare intermediaries and carriers to provide medical information to us or its designee so that we can process Medicare-related claims and provide the benefits of this Contract.

E. This Contract Is Not Assignable. Only Covered Persons can receive the benefits provided under this Contract for payment. Therefore, except as otherwise specifically set forth elsewhere in this Contract, any attempt to assign benefits or payments for benefits will be void unless authorized by us in writing, and no benefits, payments or rights may be claimed under any attempted assignment.

F. Effect of Termination or Benefit Changes. If this Contract or any benefit under this Contract ends or is changed or the coverage of a Covered Person ends, we will not provide any benefits for any care that occurs after the date the benefit is changed or coverage ends even if the care is part of a course of treatment which began during the coverage period. However, if a Covered Person is totally disabled when coverage ends, the Covered Person may be eligible to receive benefits under this Contract limited to the expenses related to the injury or illness which caused the total disability. These benefits may continue for a period of twelve (12) months following the date coverage ended as long as the Covered Person is continuously disabled, unless coverage is afforded for the total disability under another group plan.

These benefits will end if the Covered Person does not remain totally disabled or if he reaches the maximum benefits of this Contract.

We may add, delete, or otherwise modify benefits and may adjust your premiums after we provide reasonable notice to you. When care is received after a change of benefits, benefits are only available at the scope and level of benefits in effect on the date such care is rendered.

No agent has authority to change this Contract or waive any of its provisions. No change is valid unless approved by an officer of Empire HealthChoice, Inc. and evidenced by endorsement on the policy. A change may also be valid when it is in the form of an amendment to the policy signed by the group and us.

G. Physical Examination. We may require a Covered Person to undergo a physical examination as often as reasonably necessary in connection with any injury or illness which results in a claim under this Contract.

H. Right to Develop Guidelines and Group Administrative Rules. We may develop or adopt standards which describe in more detail when we will or will not make payments under this Contract and administrative rules pertaining to Group eligibility and 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

Contract, including, without limitation thereto, the power to construe this Contract, to determine all questions arising under this Contract, and to make and establish (and thereafter change) rules and regulations and procedures with respect to this Contract. If you or a Covered Person have a question about the standards which apply to a particular benefit or the Group administrative rules, you or the Covered Person may contact us and we will explain the standards or rules.

Empire HealthChoice, Inc. is an insurance company organized under the laws of New York State. Empire HealthChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. It is not acting as an agent of the Blue Cross and Blue Shield Association, and is solely responsible for honoring its agreements to insure or administer its customers' health benefits programs.

AMENDMENT TO MEMBER'S EVIDENCE OF COVERAGE

Empire HealthChoice Assurance, Inc.
P.O. Box 1407 Church Street Station
New York, NY 10008

You are hereby notified that pursuant to Empire HealthChoice, Inc.'s conversion to a for-profit health insurer and corporate merger with Empire HealthChoice Assurance, Inc., all references in your certificate of coverage and/or benefit booklet ("evidence of coverage") to "Empire HealthChoice, Inc." are hereby changed to "Empire HealthChoice Assurance, Inc."

Any claim or any right against Empire HealthChoice, Inc. you may have had under your group's contract as of the date of the conversion and merger (including, but not limited to, a right to receive payments for services incurred prior to the date of the conversion and merger) will, as a result of the conversion and merger, be against Empire HealthChoice Assurance, Inc. instead. All benefits for services received on or after the date of the conversion and merger shall be the responsibility of Empire HealthChoice Assurance, Inc.

All correspondence and inquiries concerning your coverage, including premium payments, contract changes, and notices of claims, should be submitted to:

Empire HealthChoice Assurance, Inc.
P.O. Box 1407 Church Street Station
New York, NY 10008

Except as set forth in this Amendment, your rights as a group member will not be affected and the terms and conditions of your coverage will not be changed by reason of the conversion and merger. This Amendment forms a part of and should be attached to your evidence of coverage issued to you by Empire HealthChoice, Inc.

This Amendment hereby amends your evidence of coverage by adding the following provisions:

1. The group contract is between your group and Empire HealthChoice Assurance, Inc.

2. No statement you make will void the insurance provided by the contract or evidence of coverage, or reduce its benefits, unless it is contained in a written document you have signed. All statements contained in such a document will be deemed representations, not warranties.

3. No agent has authority to change the contract or evidence of coverage or waive any of its provisions. No change in the contract or evidence of coverage shall be valid unless approved by an officer of Empire HealthChoice Assurance, Inc. and evidenced by endorsement on the contract. A change may also be valid when it is in the form of an amendment to the contract signed by the group and Empire HealthChoice Assurance, Inc.

4. All new employees or new members in the classes eligible for insurance must be added to the class for which they are eligible.

5. CONVERSION. The provisions of the group contract and your evidence of coverage that describe the conversion privilege upon termination of coverage are deleted and replaced with the following:

    - If the insurance on an employee or member insured under the group contract ceases because of termination of (i) employment or of membership in the class or classes eligible for coverage under the contract or (ii) the contract, for any reason whatsoever, unless the contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group contract for at least three months shall be entitled to have issued to him by Empire without evidence of insurability upon application made to Empire within forty-five days after such termination, and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the form and amount of insurance, an individual contract of insurance. Empire may, at its option elect to provide the

insurance coverage under a group insurance contract, delivered in this state, in lieu of the issuance of a converted individual contract of insurance. Such individual contract, or group contract, as the case may be, is hereafter referred to as the converted contract. The benefits provided under the converted contract shall be those required by subsection (f), (g), (h) or (i) of Section 3221 of the New York State Insurance Law, whichever is applicable and, in the event of termination of the converted group contract of insurance, each insured thereunder shall have a right of conversion to a converted individual contract of insurance.

- Written notice by your group given to you or mailed to your last known address, or written notice by Empire sent by first class mail to you at the last address furnished to Empire by your group, shall be deemed full compliance with the provisions of this subsection for the giving of notice.

- The converted contract shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group contract. If delivery of any individual converted contract is to be made outside this state, it may be on such form as Empire may then be offering for such conversion in the jurisdiction where such delivery is to be made.

- Notice of such conversion privilege and its duration shall be given by the contract holder to each certificate holder upon termination of his group coverage.

6. The provisions of the group contract and your evidence of coverage that describe claim submission requirements are deleted and replaced with the following:

   - Written proof of claim for benefits covered under the contract must be furnished to Empire within ninety days after the date of services were rendered. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

   - Empire will furnish to the person making claim or to the group for delivery to such person, upon request, such forms as are usually furnished by it for filing proof of claim. If such forms are not furnished in response to such request, the person making such claim shall be deemed to have complied with the requirements of the contract as to proof of claim upon submitting within the time fixed in the contract for filing proof of claim, written proof covering the occurrence, character and extent of the services for which claim was made.

7. Benefits payable under the group contract and your evidence of coverage will be payable not more than 45 days after receipt of a claim, except in a case where our obligation to pay a claim submitted is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the Insurance Department that such claim was submitted fraudulently.

8. The provisions of the group contract and your evidence of coverage that describe who will receive payment under the contract are deleted and replaced with the following:

   - All benefits of the group contract and your evidence of coverage are payable to the insured. Payments under the group contract and evidence of coverage for services provided by participating providers will be made directly to the participating provider.

9. Termination and Nonrenewal. The provisions of the group contract and your evidence of coverage that describe the termination and nonrenewal of the group contract are deleted and replaced with the following:

   (A) The group may terminate the contract with Empire at any time upon 60 days notice. The group contract will be renewed and continued in force, except that Empire may nonrenew or discontinue coverage under the group contract based only on one or more of the following:

      (1) The group has failed to pay premiums or contributions in accordance with the terms of the group contract or Empire has not received timely premium payments.

(2) The group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
(3) The group has failed to comply with the material plan provision relating to employer contribution or group participation rules, as permitted under section four-thousand two hundred thirty-five of the Insurance Law of the State of New York.
(4) Empire ceases to offer group or blanket policies in a market in accordance with this provision.
(5) The group ceases to meet the requirements for a group under section four thousand two hundred thirty-five of the Insurance Law of the State of New York, or a participating employer, labor union, association or other entity ceased membership or participation in the group to which the contract is issued. Coverage terminated pursuant to this paragraph shall be done uniformly without regard to any health status-related factor relating to any covered individual.
(6) Where Empire offers a group contract in a market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides or works in Empire's operating area.
(7) Such other reasons as are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of ("HIPAA") the Act.

(B) In any case where Empire decides to discontinue offering a particular class of group contract of hospital, surgical or medical expense insurance offered in the small or large group market, the contract of such class may be discontinued only if:

(1) Empire provides written notice to the superintendent and to each contract holder provided coverage of this class in such market (and to all participants and beneficiaries covered under such coverage) of such discontinuance at least ninety (90) days prior to the date of discontinuance of such coverage; and
(2) Empire offers to each contract holder provided coverage of this class in such market, the option to purchase all (or, in the case of the large group market, any) other hospital, surgical and medical expense coverage currently being offered by Empire to a group in such market; and
(3) Empire acts uniformly without regard to the claims experience of those contract holders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.

(C) In any case in which Empire elects to discontinue offering all hospital, surgical and medical expense coverage in the small group market or the large group market, or both markets, in the state, health insurance coverage may be discontinued only if:

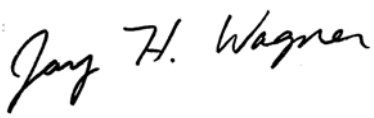
(1) Empire provides written notice to the superintendent and to each contract holder (and participants and beneficiaries covered under such coverage) of such discontinuance at least one hundred eighty days prior to the date of the discontinuance of such coverage;
(2) all hospital, surgical and medical expense coverage issued or delivered for issuance in this state in such market (or markets) is discontinued and coverage under such policies in such market (or markets) is not renewed; and
(3) Empire provides the Superintendent with a written plan to minimize potential disruption in the marketplace occasioned by its withdrawal from the market.

10. Any references in the group contract and your evidence of coverage which describe Empire's right to modify the group contract or your evidence of coverage are deleted and replaced with the following:

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

11. All terms, conditions, limitations, and exclusions of the group contract and evidence of coverage apply to this Amendment except where specifically changed herein. If there are any inconsistencies between this Amendment and the group contract and evidence of coverage, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Empire HealthChoice, Inc. and Empire HealthChoice Assurance, Inc. have caused this Amendment to Member's Evidence of Coverage to be duly signed and issued.



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

Empire BlueCross BlueShield

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO DELETE
PRE-EXISTING CONDITION EXCLUSION

This Rider increases coverage under your Certificate as follows:

1. Pre-Existing Condition Exclusion Deleted. The section of your Certificate, entitled "Pre-Existing Conditions," is hereby deleted in its entirety. We will not impose a waiting period for any pre-existing condition or complications of a pre-existing condition.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER PROVIDING BENEFITS FOR OUT-OF-NETWORK RADIOLOGY AND LABORATORY SERVICES

This Rider increases coverage under your Empire HealthChoice Assurance, Inc. Contract or Certificate by adding the following out-of network benefits:

1. Diagnostic X-ray and Other Imaging Services. Out-of-Network benefits are available for diagnostic X-ray and other imaging services, including interpretation and report for services performed in the doctor's office or outpatient department of a Hospital. Benefits are not available for diagnostic X-ray and other imaging services customarily provided by the Hospital as part of the inpatient stay when the Covered Person is an inpatient.

2. Laboratory Service. Out-of-Network benefits are available for laboratory services, including interpretation and report at laboratories.

3. These benefits are subject to the deductible and co-insurance amounts listed on the group's schedule of benefits.

4. The prior authorization requirements, and all other terms and limitations of your Empire HealthChoice Assurance, Inc. Contract or Certificate also apply to this rider.

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

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.

EMPIRE HEALTHCHOICE ASSURANCE, INC.

WOMEN'S HEALTH AND CANCER RIGHTS ACT RIDER

This Rider increases the hospital and/or medical and/or extended medical coverage under your Contract, Certificate or Group Plan.

1. **Services Covered Following Mastectomies.** In addition to the benefits provided under your medical and/or extended medical coverage for breast reconstruction surgery, we will provide coverage for the following services in connection with a mastectomy:

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

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

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER FOR INFERTILITY TREATMENT SERVICES

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

1. **Infertility Defined.** For the purposes of this Rider, infertility has the meaning set forth in regulations of the New York State Insurance Department. In general, infertility means the inability of a couple to achieve a pregnancy after 12 months of unprotected intercourse, as further defined in regulations.

2. **Covered Services.** Subject to the other provisions of this Rider and your Contract, Certificate or Group Plan, we will provide benefits under this Rider for:

   A. Medical and surgical procedures, such as artificial insemination, intrauterine insemination, and dilation and curettage ("D & C"), including any required inpatient or outpatient hospital care, that would correct malformation, disease or dysfunction resulting in infertility ; and

   B. Services in relation to diagnostic tests and procedures necessary:
      1. to determine infertility; or
      2. in connection with any surgical or medical procedures to diagnose or treat infertility. The diagnostic tests and procedures covered by this Rider are:
         - hysterosalpingogram;
         - hysteroscopy;
         - endometrial biopsy;
         - laparoscopy;
         - sono-hysterogram;
         - post-coital tests;
         - testis biopsy;
         - semen analysis;
         - blood tests;
         - ultrasound; and
         - other Medically Necessary diagnostic tests and procedures, unless excluded by law; and

   C. If the Contract, Certificate or Group Plan to which this Rider is attached covers prescription drugs, it will also include, prescription drugs approved by the FDA specifically for the diagnosis and treatment of infertility, which are not related to any excluded services. This prescription drug benefit is subject to the same conditions, exclusions, limitations and requirements that apply to all other prescription drugs under your Contract, Certificate or Group Plan, except as specifically modified by this Rider.

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

3. **Deductibles, Copayments and Coinsurance.** The benefits of this Rider are subject to any applicable deductible, copayment, or coinsurance provisions of your Contract, Certificate or Group Plan that apply to the services or treatment rendered.

4. **Services Must Be Medically Necessary.** We will not provide benefits for a service to diagnose or treat infertility if we determine, in our sole judgment, that the service was not "medically necessary," as that term is defined in your Contract or Certificate.

5. **Excluded Services.** We will not pay benefits for any services related to or in connection with:
   - In-Vitro Fertilization;
   - Gamete Intra-Fallopian Transfer (GIFT);
   - Zygote Intra-Fallopian Transfer (ZIFT);
   - Reversal of elective sterilizations, including vasectomies and tubal ligations;
   - Sex change procedures;
   - Cloning;
   - Other procedures or categories of procedures excluded by statute.

6. **Experimental Procedures Not Covered.** This Rider does not cover services or procedures that we, in our sole judgment, determine to be experimental, according to standards and guidelines that are no less favorable than those established and adopted by the American Society for Reproductive Medicine. You may appeal our determination that a service or procedure is experimental to an external appeal agent as described in the External Appeal provision of your Contract or Certificate.

7. **New Contract After Termination of Coverage May Not Contain The Benefits Of This Rider.** The new contract to which you may be entitled if your coverage under your Contract, Certificate or Group Plan ends may not include any of these infertility benefits provided by this Rider.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

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

1. The Mammography Screening Benefit in the contract or certificate to which this rider is attached is deleted and replaced with the following language:

   Benefits are available for mammography screenings for occult breast cancer as follows:

   Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first-degree relative with a prior history of breast cancer. This includes, but is not limited to a covered person's mother, sister or child.

   A single baseline mammogram for covered persons age 35 through age 39 inclusive.

   An annual mammogram for covered persons aged 40 and older.

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

2. This benefit shall be subject to any applicable deductibles, coinsurance or co-payments required under the Contract or Certificate to which this rider is attached.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

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

Bone Density Testing and Treatment

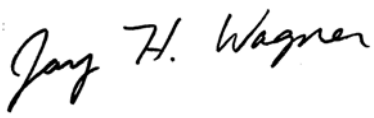
Benefits are available for bone mineral density measurements or tests. This includes measurements and tests which are covered under the standards and criteria of the federal Medicare program and the National Institutes of Health, including, as consistent with such criteria, dual-energy X-ray absorptiometry. If the Contract or Certificate to which this rider is attached provides prescription drug coverage, such coverage will include drugs and devices approved by the federal Food and Drug Administration or generic equivalents approved as substitutes.

Coverage is available for individuals that Empire determines meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall, at a minimum, include individuals:

a. previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
b. with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
c. on a prescribed drug regimen posing a significant risk of osteoporosis; or
d. with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
e. with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

These benefits shall be subject to any applicable deductibles, coinsurance or co-payments required under the Contract or Certificate to which this rider is attached.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

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

Subrogation

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

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

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

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

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

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.

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO CONTRACT/CERTIFICATE PROVIDING HOSPITAL, MEDICAL AND/OR EXTENDED MEDICAL BENEFITS

This Rider amends your contract or certificate by adding the following language to the Article listing "Exclusions" or "Exclusions and Limitations":

- "Benefits are not available and coverage will not be provided for services rendered by a member of the Covered Person's immediate family."

Other than as stated above, there is no change in any of the terms of the contract to which this Rider is attached.

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

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.

EMPIRE HEALTHCHOICE ASSURANCE, INC.

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

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

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

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

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

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

   Coverage for outpatient services for mental health care is limited to facilities that have an operating certificate issued pursuant to Article 31 of the New York Mental Hygiene Law or in a facility operated by the Office of Mental Health; or when provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of section 3221(l)(4)(D) of the New York Insurance Law, a professional corporation or a university faculty practice corporation.

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

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

3. **Out-of-Network Coverage.** If Your Contract, Certificate or Group Health Plan provides Out-of-Network Benefits or coverage for services of Non-Participating Providers, both In-Network and Out-of-Network Benefits, or services of both Participating and Non-Participating Providers, will be counted toward the benefit maximums and limitations for services provided by this Rider.

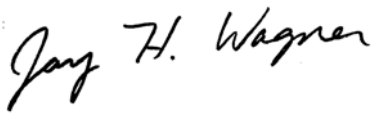
Services provided by Empire HealthChoice Assurance Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

4. **Cost-Sharing Requirements and Contract Maximums.** The cost sharing requirements and Contract day maximums for Inpatient, and visit maximums for Outpatient mental health care and alcohol and substance abuse care are listed on the Schedule of Benefits attached to your Contract or Certificate.

   Coinsurance payments for In-Network and Out-of-Network mental health and alcohol and substance abuse care coverage, if applicable, will be applied to the Covered Person's Annual Out-of-Pocket Coinsurance Maximum.

5. **Services Not Covered.** Nothing in the Rider shall be construed to cover benefits for mental health, alcohol and substance abuse services: for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or to a custodial facility for youth operated by the Office of Children and Family Services; solely because such services are ordered by a court; that are cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs; that are experimental or investigational treatments; residential treatment services; or that are otherwise excluded under your Contract, Certificate or Group Health Plan.

6. **New Contract after termination of coverage may not contain the benefits of this Rider.** The new Contract to which you may be entitled if your coverage under your Contract, Certificate or Group Health Plan ends may not include any of the benefits of this Rider.



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

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

RIDER TO YOUR CONTRACT OR CERTIFICATE REGARDING ENROLLING A NEWBORN CHILD

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

A. For a Member who has individual (for self only), employee\spouse, or parent\child (two-person) coverage:

1. He\she MUST notify the Company of his\her desire to switch to a parent\child, parent\children, or family contract within sixty (60) days after the date of birth.
2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative and submitting an enrollment form in order to have the newborn's enrollment retroactive to the date of birth.
3. If the Company does not receive enrollment notification within sixty (60) days, coverage will begin on the date that we receive, and accept from the Group, a completed copy of the Member enrollment form, provided that it is during the next open enrollment period after the birth or within the first year after the birth, which ever occurs first.
4. If you do not switch to a parent\child, parent\children, or family contract and enroll your newborn under that contract as described above, your newborn or proposed adopted newborn will NOT be covered under your Contract, Certificate or Group Plan, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery.

B. For a Member who has family or parent\children (more than two person) coverage:

1. A newborn child, or a proposed adopted newborn, will be covered from the date of birth.
2. He\she MUST formally add his\her newborn or a proposed adopted newborn to his\her contract within sixty (60) days from the date of birth by contacting his\her Group Benefit Administrator, Broker, or Company Representative as well as submitting an enrollment form.
3. Coverage will still be effective from the date of birth for a newborn or a proposed adopted newborn if an enrollment form is received after sixty (60) days, and enrollment will still be retroactive to the date of birth.
4. Any claims for a newborn or a proposed adopted newborn received after sixty (60) days will not be processed until the newborn or proposed adopted newborn is formally enrolled, except for newborn nursery charges incurred during the first 48 hours following a vaginal delivery or the first 96 hours following a c-section delivery .

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

CONTINUATION OF COVERAGE RIGHTS FOR DEPENDENTS THROUGH AGE 29

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

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

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

B. Eligible Criteria

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

1. be the unmarried dependent of a covered member;

2. be under age 30;

3. not be insured by, or eligible for coverage through the dependent's own employer-sponsored group policy, whether insured or self-insured;

4. live, work or reside in New York State; and

5. not be covered by Medicare.

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

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

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

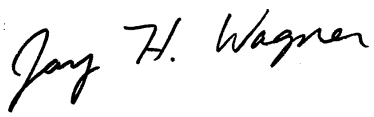
Services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

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

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

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

REGARDING EXTENSION OF CONTINUED COVERAGE AFTER LOSING ELIGIBILITY

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

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

When a Covered Person May Continue Group Coverage After Losing Eligibility in the Group. Under certain circumstances, described below, Covered Persons who would otherwise lose coverage under the eligibility provision of their group plan may retain group coverage as "Continued Coverage Beneficiaries" for limited periods of time noted below.

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

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

   a. When a Covered Person's employment terminates for any reason, other than gross misconduct, or the number of hours he works is reduced so that he is no longer eligible for group coverage, continued coverage under COBRA is available for up to eighteen (18) months. (This may not apply to certain nonresident aliens with United States source-earned income of up to three thousand dollars ($3,000)).

   b. Such eighteen (18) month period of coverage may be extended for up to an additional eleven (11) months for a total of twenty-nine (29) months if the Covered Person is determined to be disabled under the Social Security Act at the time of termination of employment or reduction of hours or at any time during the first 60 days of continuation of coverage. Such Covered Person must provide notice to the Group Health Plan Administrator before the end of the initial eighteen (18) months and within sixty (60) days of such disability determination. If the Covered Person is determined to be no longer disabled under the Social Security Act, such Covered Person must provide notice to the Group Health Plan Administrator within thirty (30) days of such determination.

   c. When a Covered Person is no longer eligible for group coverage under this Certificate because (i) he no longer qualifies for coverage under the definition of "Children," (ii) the Member dies, (iii) the Member is divorced or legally separated from his spouse, or (iv) the Member becomes entitled to Medicare, continued coverage is available for the dependents under COBRA for up to thirty-six (36) months.

d. If a Continued Coverage Beneficiary experiences one of the events listed in paragraph (c) above during his eighteen (18) month period of continued coverage, he may receive an additional eighteen (18) months of continued coverage for a maximum of thirty-six (36) months of continued coverage. Such additional coverage is measured from the date of the event for which he first became entitled to continued coverage, as set forth in paragraph (a) above. Under certain circumstances, a Continued Coverage Beneficiary is entitled to thirty-six (36) months of continued coverage as measured from the date of Medicare entitlement. This could result in a total of more than thirty-six (36) months of continued coverage.

e. Continued coverage may be available under this Certificate because the Member who is a retiree loses coverage due to the Group's commencement of proceedings under Title 11 of the Federal Bankruptcy law. Continuation Coverage for such retirees and their surviving spouses can be lifetime, and can extend up to thirty-six (36) months after the death of the retiree for the surviving spouse and dependent children. Termination of continued coverage may be subject to special requirements.

2. Notification Requirements Under COBRA

a. The Covered Person must notify the Group within sixty (60) days after (i) a divorce or legal separation, (ii) the date he or a family member no longer qualifies for coverage under the definition of "Children" in the Certificate, or (iii) the date coverage would otherwise end due to such an event, whichever is the latest.

b. The Group must separately notify each Continued Coverage Beneficiary of his right to continue coverage in accordance with COBRA within fourteen (14) days after learning of a qualifying event.

3. Election of Continued Coverage

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

4. Payment of Premiums

a. Under COBRA, Continued Coverage beneficiaries have the right to pay premiums not more than once a month.

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

5. Termination of Continued Coverage

a. Under COBRA, continued coverage generally ends at the earliest of the following:

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

the other group Contract has expired, or b) the applicable eighteenth (18th), twenty-ninth (29th) or thirty-sixth (36th) month of coverage has expired, or

(ii) eighteen (18) months after the date of one of the events described in paragraph 1 (a), or

(iii) twenty-nine (29) months after the date of one of the events described in paragraph 1 (a), unless sooner terminated because the Continued Coverage Beneficiary is determined to be no longer disabled under the Social Security Act, or

(iv) thirty-six (36) months after the date of one of the events described in paragraph l (c) or l (d).

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

(i) The Continued Coverage Beneficiary fails to pay the premiums when due.

(ii) The Group no longer provides group health insurance to any of its employees or members.

(iii) The Continued Coverage Beneficiary becomes entitled to Medicare.

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

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

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

7. The Right to Convert Coverage When Continued Coverage Ends

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

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

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

9. Notification Requirements Under New York State Law

a. The Covered Person must notify the Group in writing within sixty (60) days after the date employment ends, or the date he is sent notice by first class mail of his right of continuation by the Group, whichever is later.

b. If a Covered Person is disabled under Title II or Title XVI of the Social Security Act at the time employment ends or within the first sixty (60) days of continued coverage, he must notify the Group within sixty (60) days of the determination of disability under the Social Security Act.

10. Payment of Premiums for New York State Continued Coverage

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

11. Termination of New York State Continued Coverage

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

a. Thirty-six (36) months after the Covered Person's benefits under the policy would otherwise have ended because of termination of employment or membership in an eligible class; or
b. The end of the period for which premium payments were made, if the Covered Person fails to pay the premium when due; or
c. In the case of an eligible dependent of a Covered Person, thirty six (36) months after the date the dependent's benefits under the policy would otherwise have terminated by reason of:

(i) the death of the Covered Person;
(ii) the divorce or legal separation of the Covered Person from his or her spouse;
(iii) the Covered Person becoming entitled to benefits under Title XVIII of the Social Security Act; or
(iv) a dependent child ceasing to be a dependent child under the terms of this Certificate.

d. The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this clause applies and the coverage is replaced by similar coverage under another group policy:

(i) The Covered Person has the right to be covered under the other group policy for the rest of the period that he would have remained covered under the prior group policy, and
(ii) The minimum level of benefits to be provided by the other group policy will apply to the Covered Person but will be reduced by any benefits payable under the prior group policy, and
(iii) The prior group policy will provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred; or

e. The date on which the Covered Person becomes covered by any other arrangement that provides hospital, surgical or medical coverage for individuals in a group and does not contain any limitation with respect to a pre-existing condition of the Covered Person.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

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

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

Subsection A, "A Prerequisite for Benefits Provided Under This Contract," is deleted in its entirety and replaced with the following:

A. A Prerequisite for Benefits Provided Under This Contract.

1. The Medical Management Program (MMP) is a program which the Covered Person must comply with in order to be eligible to receive the maximum benefits available under this Contract. MMP works with Covered Persons and/or their doctors to ensure that Covered Persons receive medically appropriate health services at an appropriate level of medical care.

   The Covered Person is responsible for ensuring that the pre-certification requirements are met unless this Contract specifically states otherwise. If the requirements described in this Article are not met, we will apply the penalty described to the benefits otherwise available under this Contract. The penalties are in addition to cost sharing requirements listed in the Schedule of Benefits and do not apply to the satisfaction of cost share maximums.

2. The following services are covered and must be preauthorized by MMP. **Failure to precertify may result in a penalty of 50% up to $2,500 on each visit or admission, for the following services.** The penalty may apply to the professional visits for services rendered during inpatient admissions and ambulatory surgery.

   - All inpatient admissions, including admissions for illness or injury to newborns;
   - Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification;
   - Outpatient/Ambulatory Surgical Treatments (certain procedures);
   - Physical, Occupational, Vision, and Speech Therapy;
   - Diagnostics;
   - Outpatient Treatments;
   - Air Ambulance;
   - Durable Medical Equipment.

3. The Covered Person, the provider or someone else on behalf of the Covered Person, may telephone MMP or the Mental and Behavioral Health Care Manager at the number indicated on the Covered Person's Identification Card to request for pre-certification before services are rendered or as follows:

   a. At least two weeks prior to the planned admission or surgery when a doctor recommends inpatient hospitalization, or if that is not possible, then during regular business hours any time prior to surgery.

   b. Before Air Ambulance services are rendered, or within forty-eight (48) hours after admission to or treatment at a hospital, when needed to transport a Covered Person to the nearest acute care hospital in connection with an Emergency Condition, as outlined above, when the following conditions are met:

- A Covered Person's medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances or other geographic obstacles, and the use of land transportation would pose an immediate threat to the Covered Person's health.

- Services will be covered for an In-Network air ambulance used to transport a Covered Person from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for the Covered Person's treatment as determined by Empire, and use of a land ambulance would pose an immediate threat to the Covered Person's health.

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

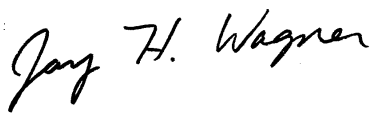
c. Within the first three months of a pregnancy, or as soon as reasonably possible, and again within forty-eight (48) hours after the actual delivery date if stay is expected to extend beyond the minimum length of stay for mother and newborn inpatient admission: forty-eight (48) hours for a vaginal birth;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

d. At least two weeks prior to all ambulatory surgery or any ambulatory care procedure when a doctor recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in a free standing ambulatory surgery facility. If precertification cannot be obtained from Medical Management during regular business hours any time prior to surgery, and if a Covered Person receives care as a Hospital inpatient for the types of services which could be performed on an outpatient basis, then we will provide only the reimbursement we would have paid for ambulatory surgery.

4. The staff will discuss the planned level of care with the Covered Person and his attending doctor to determine a level of care which is appropriate to the planned health services and advise the Covered Person, his attending doctor, and the Hospital in writing and by telephone of the approved level of care within three (3) business days after the staff receives all the necessary medical information from the attending physician. If during a hospitalization or course of treatment you need authorization for continued or extended health care, the Medical Management Program will respond within one business day of receiving the necessary medical information.

5. The preauthorization of benefits by the MMP or the mental and behavioral health care manager does not guarantee payment of benefits. All benefits must be medically necessary as determined by us. The payment of benefits is limited by the terms, conditions and limitations of this Contract.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT REGARDING SPECIAL ENROLLMENT PERIODS

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

A. Article I, "General Information," Section E, "When Coverage Under The Group Begins," bullet 5. is replaced in its entirety as follows:

5. An eligible Member, or dependent of a Member, who rejects initial enrollment under this Contract can become covered under this Contract if the following special enrollment conditions are met:

   A. The Member or dependent was covered under another plan at the time coverage under this Contract was initially offered, and

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

      ii. Coverage under the other plan was subsequently terminated as a result of loss of eligibility for one or more of the following:
      - Termination of employment;
      - termination of the other plan;
      - death of the spouse;
      - legal separation, divorce or annulment;
      - reduction in the number of hours of employment;
      - an employer no longer offering benefits to a class of individuals such as part time workers;
      - lifetime maximum being met under such insurance, or

      iii. Contract holder contributions toward the payment of premium for the other plan were terminated.

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

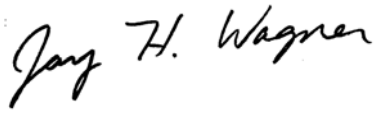
   C. Coverage must be applied for within thirty (30) days of one of the qualifying special enrollment events described above in this section.

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

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

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

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



Jay H. Wagner
Corporate Secretary

Mark Wagar
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

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

1. **Article I, "GENERAL INFORMATION," D., "Group Enrollment,"** definition of, **"Spouse,"** is hereby deleted in its entirety and replaced with the following:

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

2. **Article XIII, "LIMITATIONS AND EXCLUSIONS," C., "Benefits for Medicare Eligibles Who Are Covered Under This Contract,"** is hereby deleted in its entirety and replaced with the following:

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

    2. If your Group has one hundred (100) or more employees or your Group is an organization which includes an employer with one hundred (100) or more employees, any active employee, spouse of an active employee or dependent child of an active employee who becomes or remains a member of your Group covered by this Contract after becoming eligible for Medicare due to disability will receive the benefits of this Contract as primary. The Group must notify us of the Covered Person's election and pay the appropriate premiums. If such Covered Person elects Medicare as primary, such Covered Person shall not be eligible for coverage under this Contract as of the date of such election.

    3. Any Covered Persons who are not subject to subsections 1 and 2 of this Section and who are Medicare eligible will receive the benefits of this Contract reduced by any benefits available under Medicare. This applies even if the Covered Person fails to enroll in Medicare or does not claim the benefits available under Medicare.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

This Rider amends the Contract, Certificate or Group Plan issued by Empire HealthChoice Assurance, Inc. ("Empire," "We," or "Us") to which it is attached as described below.

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.

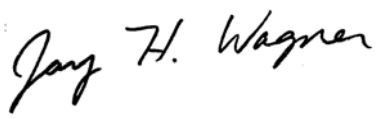
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Certificate, Contract or Group Plan, and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

Empire is committed to communicating with our members about their health plan, regardless of their language. Empire employs a Language Line interpretation service for use by all of our Member Service Call Centers. Simply call the Member Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

MAXIMUM ALLOWED AMOUNT
REIMBURSEMENT FOR COVERED SERVICES

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

A. The definition of **"Allowed Amount"** appearing in **ARTICLE I – GENERAL INFORMATION** and elsewhere in Your Plan is hereby replaced with the following:

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

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

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

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

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

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

PROVIDER NETWORK STATUS

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

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

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

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

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

For Emergency Services that you receive from an Out-of-Network Provider, the Maximum Allowed Amount will be based on the greater of: (1) the amount negotiated with In-Network Providers for the Emergency Service received; (2) 100% of the allowable amount for Emergency Services provided by an Out-of-Network Provider under the Plan; (3) or the amount that would be paid under Medicare. Empire's payment obligation will not exceed actual billed charges.

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

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

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

MEMBER COST SHARE

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

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

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

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

The following are examples for illustrative purposes only. Please see Your Schedule of Benefits for Your applicable amounts.

Example: Your Plan has Coinsurance of 20% for In-Network services, and 30% Out-of-Network after the In- or Out-of-Network Deductible has been met. You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

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

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

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

AUTHORIZED SERVICES

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

The following are examples for illustrative purposes only. Please see Your Schedule of Benefits for Your applicable amounts.

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

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

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

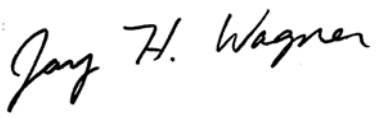
Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325.

B. All references to **"Allowed Amount," "Usual and Customary Charges," "Customary Charges," "Maximum Allowance," "Maximum Allowable Charge,"** wherever they appear, are hereby changed to **"Maximum Allowed Amount."**

C **ARTICLE XII – MEDICAL BENEFITS**, section **A. "Anesthesia Service,"** is hereby deleted in its entirety and replaced with the following:

A. Anesthesia Service. Benefits are available for anesthesia services received as part of a covered surgical procedure. The Maximum Allowed Amount for anesthesia includes consultation by an anesthesiologist before surgery and routine services during and following surgery and is not separately payable when anesthesia is rendered by the surgeon or the surgeon's assistant as part of the covered surgical procedure. The Maximum Allowed Amount for anesthesia includes consultation by the anesthesiologist before surgery and routine services during and following surgery.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CONTRACT OR CERTIFICATE

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

The description of **"Blue Cross and Blue Shield Association Blue Card Program", "Access to Care Outside of Plan Area through Blue Cross and Blue Shield Association BlueCard Program"** appearing in **ARTICLE I – GENERAL INFORMATION** and elsewhere in Your Contract is hereby replaced with the following:

1. Inter-Plan Programs

A. Out-of-Area Services

Empire has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Empire's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Empire and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Empire's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Empire's payment practices in both instances are described below.

B. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Empire will remain responsible for fulfilling Empire's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Empire's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Empire.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Empire uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if Empire pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Empire may collect such amounts directly from you. You agree that Empire has the right to collect such amounts from you.

C. Non-Participating Healthcare Providers Outside Empire's Service Area

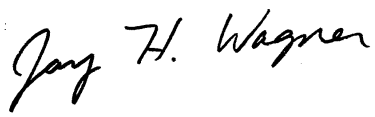
1. Your Liability Calculation

   When covered healthcare services are provided outside of Empire's service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the Covered Services as set forth in this paragraph.

2. Exceptions

   In certain situations, Empire may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Empire will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Empire will make for the covered services as set forth in this paragraph.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

RECOVERY OF CLAIM OVERPAYMENTS

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

Recovery of Overpayments

On occasion a payment will be made when a Covered Person is not covered, for a service which is not covered, or which is more than is due under your Plan. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. When this happens we will explain the problem to the Covered Person and he must return to us within sixty (60) days the amount of the overpayment. However, we will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide the Covered Person with notice of overpayments made by Us or the Covered Person if the recovery method makes providing such notice administratively burdensome.

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

Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

AMENDMENT TO GROUP INSURANCE CONTRACT

This Amendment revises and becomes a part of the Contract issued to the Group. In the event of conflict between this Amendment and the Contract, the terms of this Amendment will control.

ARTICLE I of the Contract is amended to add the following new provisions:

F. MLR Rebate.

For any rebate due and payable as a consequence of the medical loss ratio ("MLR") requirements of the Patient Protection and Affordable Care Act ("PPACA") and/or applicable state law, all such rebates paid shall constitute a refund of premium. Group shall promptly provide Empire with any information needed to calculate the applicable rebate amount. Empire reserves the right to pay the rebate to either the Group or to a Subscriber under the Group plan.

If Empire pays the rebate to the Group, Group shall promptly either refund to each Subscriber his/her proportional share of the rebate or use the rebate for the benefit of the Subscribers in accordance with the requirements of PPACA. Upon reasonable request, Group shall provide to Empire documentation of the distribution of the rebate to Subscribers. Group agrees to provide such documentation within the time frame designated by Empire.

In the event of an inquiry related to the amount of the rebate, Group shall cooperate with Empire and provide Empire with information required to investigate the inquiry. If Empire is required to pay additional amounts to a Subscriber due to Group's failure to (1) provide accurate information, (2) make a refund or refund less than the amount due or (3) use the rebate for the benefit of the Subscribers, Group agrees to reimburse Empire for such additional amount paid by Empire. This Article I(F) shall survive the termination of the Contract.

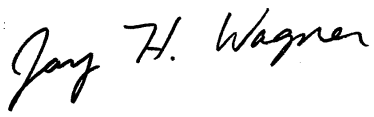
G. Summary of Benefits and Coverage.

A. In advance of the next renewal year, within the time period designated by Empire, the Employer shall provide Empire with all necessary benefit information to enable Empire to provide the Employer the Summary of Benefits and Coverage (SBC) as required by this Amendment.

B. As may be required by law, Empire shall (1) provide the Employer with an SBC and (2) provide the Employer an updated SBC in the context of a Notice of Material Modification (NMM). To the extent permitted by law, the Employer shall be solely responsible for disseminating an electronic copy (via the internet or otherwise) or a paper copy of the SBC to participants and beneficiaries (including pre-enrollees) in a manner compliant with (a) the Employee Retirement Income Security Act (ERISA), if applicable; (b) all the requirements of Section 2715 of the Public Health Service Act (PHSA) as added by Section 1001 of the Patient Protection and Affordable Care Act (PPACA) ; (c) any applicable regulations implementing PHSA Section 2715 codified in the Code of Federal Regulations; and (d) any sub-regulatory guidance regarding PHSA Section 2715. Notwithstanding the above, Employer agrees that Empire may, upon advance notice to the Employer, deliver the SBC to participants and beneficiaries via paper, electronic means, or Internet access, as permitted by law. Employer agrees that it will provide the NMM (including the updated SBC) to its participants and beneficiaries in accordance with the requirements set forth in the statutes and regulations referenced in this paragraph B. The Employer will notify Empire immediately if it fails to deliver the SBC to participants and beneficiaries

C. To the extent permitted by law, the Employer shall reimburse Empire for any fines, assessments and fees imposed on Empire by the United States Department of Health and Human Services, the United States Department of Labor and/or the United States Department of Treasury for the Employer's negligence, gross negligence or intentional acts around its failure to distribute the SBC to the group health plan participants and beneficiaries as set forth by PHSA Section 2715, 29 CFR Part 2590.715-2715, et seq. or 45 CFR Part 147.200, et seq.

Except as set forth immediately above, the Contract remains unchanged. This Amendment remains in effect until terminated in accordance with the provisions of the Contract or this Amendment.



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER TO YOUR CERTIFICATE OR CONTRACT

COVERAGE FOR AUTISM SPECTRUM DISORDER

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

We will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of Autism Spectrum Disorder.

1. Definitions:

A. ***"Autism Spectrum Disorder (ASD)"*** means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including Autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

B. ***"Applied Behavior Analysis (ABA)"*** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

C. ***"Treatment of Autism Spectrum Disorder"*** means care prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist.

2. Covered Services:

- **Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has Autism Spectrum Disorder.

- **Behavioral health treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual when provided by a licensed provider. We will provide such coverage when provided by a licensed provider. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments (over the duration of the intervention) in objective and measurable terms.

- **Applied Behavior Analysis (ABA).** We will provide coverage for Applied Behavior Analysis, when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education.

Coverage of Applied Behavior Analysis services is limited to $45,000 per Member per Contract Year. This maximum annual benefit will increase by the amount calculated from an increase in the medical component of the Consumer Price Index (CPI) as required by New York law.

Prior approval of Applied Behavior Analysis services is required. Refer to the prior approval procedures in your Contract.

- **Psychiatric and Psychological care.** We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

- **Therapeutic care.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat Autism Spectrum Disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.

- **Assistive communication devices (ACDs).** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items such as, but not limited to, laptops, desktops, or tablet computers. We will cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per covered device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

  Prior approval of assistive communication devices is required. Refer to the prior approval procedures in your Contract.

3. Benefit Provisions, Limitations and Cost-Sharing

A. We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.

B. In addition, benefits under this Rider will be subject to plan provisions for similar medical benefits under your Contract, Certificate or Group Health Plan, including the following:

- Precertification, utilization review and case management by Empire's Medical Management Program.

- Benefit maximums.

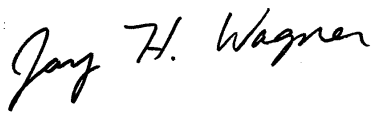
- Network provider requirements.

- Cost-sharing. You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Contract for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this Rider.

  Any Deductible, Copayment, or Coinsurance that applies to specialist office visits will apply to assistive communication devices covered under this Rider.

- Appeal procedures.

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



Jay H. Wagner
Corporate Secretary

Brian T. Griffin
President

EMPIRE HEALTHCHOICE ASSURANCE, INC.

RIDER REGARDING DISPUTES UNDER THIS CONTRACT

This Rider changes provisions in, or adds provisions to, your Contract, Certificate or Group Plan, including any affected riders, endorsements or other amendments thereto, (hereinafter collectively "Your Plan") issued by Empire HealthChoice Assurance, Inc., except as otherwise provided in this Rider, the provisions herein apply to all persons covered under "Your Plan" ("Members").

A. Utilization Review Initial Coverage Determination Timeframes.

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

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

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

1. **Standard Level 1 Appeals.** The Covered Person (or the Covered Person's authorized representative, or health care provider) may file a formal appeal by telephone or in writing. An appeal must be filed within one hundred, eighty (180) calendar days from the date of receipt of notice of a denial of services. An appeal submitted beyond the one-hundred, eighty (180) day filing limit will not be accepted for review.

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

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

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

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

2. **Expedited Level 1 Appeals.** Empire will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

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

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

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

3. **Standard Level 2 Appeals.** If the Covered Person is dissatisfied with the outcome of the Level 1 Appeal, a Level 2 Appeal may be filed with Empire within sixty (60) business days from the receipt of the notice of the letter denying the Level 1 Appeal. If the appeal is not submitted within that time frame, we will not review it and our decision on the Level 1 appeal will stand. Appeals may be filed by telephone or in writing.

    We will make a decision within the following time frames for Level 2 Appeals:

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

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

   Empire Appeal and Grievance Department
   P.O. Box 1407
   Church Street Station
   New York, NY 10008-14047

   Send appeals concerning behavioral health care to:

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

5. **External Appeals**

   a. **Your Right to an External Appeal.** Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

   b. **Your Right to Appeal a Determination That a Service is not Medically Necessary.** If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for medical necessity, you may appeal to an external appeal agent if you satisfy the following two (2) criteria:

      - The service, procedure, or treatment must otherwise be a Covered Service under the Subscriber Contract; and
      - You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

   c. **Your Right to Appeal a Determination that a Service is Experimental or Investigational.** If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two (2) criteria:

      - The service must otherwise be a Covered Service under this Subscriber Contract; and
        You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial **or** you and the Plan must agree in writing to waive any internal appeal **or** you apply for an expedited external appeal at the same time as you apply for an expedited internal appeal **or** the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

In addition, your attending physician must certify that your condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered or acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered);or
- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

d. The External Appeal Process. If, through the first level of the Plan's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary, or is an experimental or investigational treatment you have four (4) months from receipt of such notice to file a written request for an external appeal. If you and the Plan have agreed in writing to waive any internal appeal, you have four (4) months from receipt of such waiver to file a written request for an external appeal. If the Plan fails to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. The Plan will provide an external appeal application with the final adverse determination issued through the first level of the Plan's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for it to exercise its right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of this subscriber contract. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

e. Your Responsibilities. It is your RESPONSIBILITY to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your external appeal request; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed such representative.

Under New York State law, your completed request for appeal must be filed within four (4) months of either the date upon which you receive written notification from the Plan that it has upheld a denial of coverage, or the date upon which you receive a written waiver of any internal appeal, or the failure of the Plan to adhere to claim processing requirements. The Plan has no authority to grant an extension of this deadline.

f. Covered Services/Exclusions. In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an external appeal agent in accordance with Section of this subscriber contract. If the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this subscriber contract for non-experimental or non-investigational treatments provided in such clinical trial.

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

Empire Appeal and Grievance Department
P.O. Box 1407
Church Street Station
New York, NY 10008-14047

Send appeals concerning behavioral health care to:

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

We will resolve complaints within the following time frames:

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

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

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

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

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

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

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

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

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

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

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

Empire will make a decision within 48 hours of receipt of all necessary information, but in any event within seventy-two (72) hours of receipt of the grievance.
Empire will notify you immediately of the decision by telephone, and within two (2) business days in writing.

4. **Decision on Grievances.** Empire's notice of its Grievance decision (whether standard or urgent) will include:

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

5. **How to File a Grievance.** To submit an appeal or grievance, call Member Services at the telephone number located on the back of your ID card, or write to the following address with the reason why you believe our decision was wrong. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

   The address for filing an appeal or grievance is:

   Empire Appeal and Grievance Department
   P.O. Box 1407
   Church Street Station
   New York, NY 10008-14047

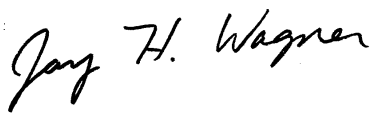
   Send appeals concerning behavioral health care to:

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

D. CHOICE OF LAW. This Contract has been issued in New York State to a Group located in New York State. In any dispute between us and the Group or any Covered Person, New York or federal law, as appropriate, shall be applied to determine the group's rights, the rights of Covered Persons, the rights of Providers and our rights.

E. TIME TO BRING LEGAL ACTION. The Covered Person must start any lawsuit against us under this Contract within two (2) years from the date the Covered Person receives the service for which payment is sought. However, a lawsuit may not be started under this Contract until sixty (60) days after the claim has been filed with us.

F. OTHER PROVISIONS. All of the terms, conditions, and limitations of the Your Plan to which this Rider is attached also apply to this Rider, except where they are specifically changed by this Rider.



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